CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

CITY HALL

BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS AS PROPOSED HEREIN, ARE ACTUALLY RECORDS OF THE DEPARTMENT OF _____ BUREAU OF _____ DIVISION, THE NORMAL RETENTION PERIODS ARE TOO LONG, THE MICROFILMING WILL BE PERFORMED TO SUPPLEMENT OTHER METHODS, AND THAT

THE MICROFILMING OF THESE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. _____ AS APPROVED BY THE RECORDS MANAGEMENT OFFICER IN ACCORDANCE WITH ORDINANCE NO. 1095 APPROVED BY THE MAYOR ON JUNE 4, 1952.

FORM NO. 1 (11-58) REP. AUG—1958

REQUEST FOR RETENTION PERIOD

Authorization No. 345

Department: Health

Bureau: Vital Statistics

To: Records Management Officer
Room 408, City Hall, Baltimore, 2, Md

Record Identification

1 TITLE: Certificate of Death

2 Form No. (if available)

3 Type - (cards, paper, etc.): Bound Book

4 Dates

5 Origin and (or) regulated activity

6 Size of Records: 8½ x 14

7 Number of copies made: One (1)

8 Authorization Requested (check only one) (1) of the squares below:

A [ ] Establish retention period for records which are accumulating daily

B [ ] Extension of present accumulation; no additional accumulation anticipated

C [ ] Withdraw prior action on item 1

D [X] Microfilm and retain for a total length of time as indicated below

9 Recommended Retention Period

a. In Dept: 12 yrs.

b. In Storage Center: Micro. Perm.

c. Total: 12 yrs. and Micro. Perm.

10 Equipment and space freed

In your opinion does this record have any historical significance? YES [ ] NO [X]

12 DESCRIPTION OF RECORD (describe accurately and show recommended retention period)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval: Robert E Farber M D — Title: Commissioner of Health — Date: 3/18/63

Recommendation of Records Management Officer

12 Recommended Retention Period

a. In Dept.: 12 yrs.

b. In Storage Center: Microfilm Permanent

c. Total: 12 yrs. and Microfilm Permanent

14 Disposal Method

A [ ] To be sold as scrap or waste paper

B [X] To be Burned or otherwise destroyed

C [ ] Historical: to be transferred to Dept of Legislative Reference

REMARKS:

C Pierce — 3/18/63
Records Management Officer

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD

1 APPROVED CITY AUDITOR

2 APPROVED CITY SOLICITOR

3 APPROVED CITY COMPTROLLER

4 APPROVED CITY TREASURER

5 APPROVED DIRECTOR DEPT OF PUBLIC WORKS

6 APPROVED DIRECTOR OF THE MUNICIPAL MUSEUM

7 APPROVED DIRECTOR, DEPT OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

5741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65741

1. PLACE OF DEATH
(a) Baltimore City Maryland
(b) Street address: Eaton & Wilkens
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst., yrs., mos., or days
(e) Length of stay in Baltimore, yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
a) State Md County
d) Street No. 1 [illegible] Fondawood Road
e) Citizen of foreign country? Yes or No
If yes, name country

3. (a) FULL NAME Margaret A Wallis

3. (b) If veteran, name war

3. (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6. (a) Single, married, widowed, or divorced: Married

6. (b) Name of husband or wife: Lawrence Watts
If widow, give age years

7. Birth date of deceased: MAY 7 1893

8. AGE: Years 73 | Months 3 | Days 2 | If less than one day: hr. min.

9. Birthplace: BALTIMORE
(Town, county, and state)

10. Usual Occupation: AT HOME

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16. (a) Informant: LAWRENCE F. WATTS.
(b) Address: 2413 HAMPDEN CHOICE LANE.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: AUG 14 1966 (month, day, year)
(c) Cemetery or crematory: NEW CATHEDRAL
Location: OLD FREDERICK RD.

18. (a) Funeral director: THE DIPPEL BROTHERS
(b) Address: 600 E LOMBARD ST.

19. Filed [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH [illegible]

21. I certify that I attended the deceased from [illegible] that I last saw the deceased alive on [illegible] and that death occurred on the date stated above, at [illegible] M.

Immediate cause of death: CARDIAC FAILURE — Duration

Due to: CORONARY OCCLUSION AND INFARCTION OF MYOCARDIUM

Due to:

Operation: Yes or No

Date of operation:

Major findings of operation:

Autopsy: YES

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide?
(b) Date of occurrence at M
(c) Where did injury occur? (Specify city or county) State
(d) Did injury occur in/about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Manner of injury
(f) Signature

PHYSICIAN

Signature and address of physician responsible for the statements in this certificate

Date signed

5742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 665742

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1918 Eutaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days ---
(e) Length of stay in Baltimore yrs. mos. or days 52 Yrs.

2 (a) FULL NAME Agnes [illegible] Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex: Female | 5. Color or race: White | Single, married, widowed or divorced: Widow

6 (b) Name of husband or wife: Thomas Kelly

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.): April 8, 189[illegible]

8. AGE: Years: 52 | Months: 4 | Days: 0 | If less than one day: --- hr. --- min.

9. Birthplace: Baltimore, Maryland
(Town, county and state)

10. Usual Occupation: None

11. Industry or business: -------

FATHER
12. Name: Michael Durkin
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Nora Kern
15. Birthplace: Ireland

16. (a) Informant: Mrs. Marie Tarrelson
(b) Address: 1411 Eutaw Place

17. (a) Burial, Cremation or Removal — Date: 6/11/37
(b) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: [illegible]
(b) Address: 805 N. Calvert Street

JUN 10 1937
(Date of registration)

Fortney H. Stallings, M.D.

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7. USUAL RESIDENCE OF DECEASED
(a) State: Md. County:
(b) City or town: Balto.,
(c) Street No.: 1918 Eutaw Place
(d) If outside city, length of stay: ------
If in city, length of residence: --------

MEDICAL CERTIFICATION

20 DATE OF DEATH: June 8, 1937

21. I certify that I last attended the deceased from June 4, 1937 to June 8, 1937; that I last saw her alive on June 4, 1937 and that death occurred at 1:30 A.M.

Inspection & Inquiry

If prompt and from the disease named

by said Autopsy findings and Inquiry, that death was due to the cause and in the manner stated.

I further certify that I have no prior medical knowledge that death was due to any other than natural causes except that it occurred on

Hour not stated, as I did not attend deceased after last visit.

IMMEDIATE CAUSE OF DEATH: My Condition
(a) Intussusception

Contributory [illegible]

22. I performed autopsy on the body of deceased. Data from which I have formed my opinion as to the cause of death are as follows: Autopsy findings

Date signed: June 10, 1937 M.D.
Where: 1411 Eutaw Place
Physician's address: 1411 Eutaw Place
Signature of physician: Fortney H. Stallings M.D.

5743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G 5743

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens ave
(c) Hospital or institution. St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(d) Street No. 2512 Emerson St.
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mary E. Woodland.
(b) If veteran, name war (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F.	W.	M.

6 (b) Name of husband or wife John W. Woodland.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July. 12-1888

8. AGE: Years	Months	Days	If less than one day: hr	min
60	0	26		

9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business
12. Name Joseph Figuette
13. Birthplace Md.
14. Maiden Name Unknown
15. Birthplace Unknown.
16 (a) Informant Mrs. Lily Daughter
(b) Address 2512 Emerson St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11-48. (month) (day) (year)
(c) Cemetery or crematory Mt. Hirst Cem.
Location Baltimore Md.
18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 Frederick Ave.
19 (a) (Date received by registrar) (b) Signature of registrar

20. DATE OF DEATH 8 - 8 - 48 at 1:20 A. M.
21. I certify that I attended the deceased from the date of last stated that I attended the deceased and that death occurred at the hour stated.
Immediate cause of death Cardiac failure
Due to (Chronic Interstitial Nephritis
Due to
Other Conditions

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (Town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
(f) Signature
Address Date signed

65744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65744

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St and Linden Ave
(c) Hospital or institution
Maryland General Hospital
(d) Length of stay in Institution or inst. yrs., mos., or days 1 day
(e) Length of stay in Baltimore yrs. mos., or days 7 days

2. USUAL RESIDENCE OF DECEASED:
State Md
City or town Centerville
Street No. Centerville
Citizen of foreign country? No
If yes, name country

3 (a) FULL NAME Roberta Cromer

3 (b) If veteran, name war — Social Security Account No.

4. Sex Female — 5. Color or race White — 6. Single, married, widowed or divorced Married

6 (b) Name of husband or wife Harry B. Chaney — If alive, give age years

7. Birth date of deceased mo. Aug. day 29 yr. 1901

8. AGE: Years 47 Months 11 Days 18 If less than one day hr. min.

9. Birthplace Strasburg, Virginia (Town, county and state)

10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name John M. Mitchell
13. Birthplace Strasburg Va.

MOTHER
14. Maiden Name Ida B. Palmer
15. Birthplace Strasburg, Va.

16 (a) Informant Harry B. Chaney
(b) Address Odenton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12, 1948 (month, day, yr.)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) AUG 10 1948 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATE OF DEATH

20 DATE OF DEATH August 10 1948 2:45 A.M.

21 I attended deceased from 8-3 1948, saw her last 8-9 1948

Immediate cause of death: Respiratory failure — Duration: 7 days
(a)
Due to: Intracranial hemorrhage with Hypertensive cardiovascular disease — (b) 1 day
Due to:
Bronchopneumonia — (c) 5 days

Contributory causes (not related to disease or condition causing death)

Date of operation
Major findings of operation:

of autopsy

Accident, suicide or homicide

(b) Date of occurrence at M

Where did injury occur?

Describe how injury occurred (home, on farm, industrial plant, public place)

Means of injury

20. Signature of physician

Address Emerg. Hosp. Date signed 8-10-48

PHYSICIAN

65745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65745

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution
Foot of Bond Street

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore (yrs., mos., or da

2. (a) FULL NAME

3. (b) If veteran, name war
World War 2

3. Social Security Account No.

4. Sex
Male

5. Color or race
White

6. (a) Single, married, widowed, or divorced
Divorced

6. (b) Name of husband or wife

(c) If alive, give age years

7. Birth date of deceased mo., day, yr. Sept. 10, 1906

8. AGE: Years 41 | Months 42 | Days

If less than one day

9. Birthplace Philadelphia, Pa.
Town, county or state

10. Usual Occupation

11. Industry or business

12. Name Harry McCauley

13. Birthplace Pennsylvania

14. Maiden Name Fannie Lonaker

15. Birthplace Pennsylvania

16. (a) Informant Harry McCauley

(b) Address 1616 Tara St. Linwood, Pa.

17. (a) Removal (Burial, cremation or removal)

(b) Date thereof

(c) Cemetery or crematory Marcus Memorial Home

Location Marcus Hook, Pa.

18. (a) Funeral director Illig and Heller, Inc.

(b) Address 129 S. Wolfe St. Balto. 31, Md.

19. AUG 10 1948

USUAL RESIDENCE OF DECEASED

State Md.

City Baltimore

Street No. 121 S. Bond Street

(c) Citizen of (country) No

If yes, give city

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1948

21. I certify that I attended the deceased from

Autopsy (Yes or No)

by said Autopsy (Inspection or inquest)

to

Operation (Yes or No)

Accident, suicide or homicide

IMMEDIATE CAUSE OF DEATH

Date to

Place of death

Time of death

Name of undertaker

Address

M.D.

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665746
AB-121739

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 665746

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or if not, yrs., mos., or days 5days
(e) Length of stay in Baltimore if not, yrs., mos., or days -12yrs- 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(d) Street No. 1919 E. Pratt St.
(e) Citizen of (foreign country) Poland (Yes or No)
If yes, name country

3. FULL NAME Wladyslaw Walter Goralski
(b) If veteran, name war (c) Social Security Account No.

4. Sex M 5. Color or race W 6. Single, married, widowed, or divorced Married

(a) Name of husband or wife Mary Goralski
(b) If married, widowed, or divorced, age 59 years

7. Birth date of deceased (Month, day, year) 1-1-1 1882

8. AGE: Years 66 Months Days If less than one day, hours or minutes

9. Birthplace Poland

10. Usual Occupation ?

11. Industry or business ?

FATHER
12. Name Joseph Goralski
13. Birthplace Poland

MOTHER
14. Maiden Name Bogumila Pietrowski
15. Birthplace Poland

16. (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17. (a) Burial, cremation, or removal (b) Date thereof aug 11 1948
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18. (a) Funeral director John J. Kelley
(b) Address 451 S. Chester Street

19. (a) AUG 10 1948 (Date received by registrar)

VS 5

20. DATE OF DEATH (Month, day, year) Aug. 8- 48 3.10 P M

21. I attended deceased from 8-3- 48 to 8-8- 48.
I last saw deceased alive on 8-8- 46

Immediate cause (a) Uremia Duration

Antecedent causes Arteriosclerotic Cardio Vascular Disease

Other significant conditions arteriosclerotic gangrene rt leg

Date of operation none

Major findings of operation

If autopsy

If death was due to external causes, fill in the following

Accident, suicide or homicide

(a) Date of occurrence at M

(b) Where did injury occur?

(c) Injury occurred in home, farm, industrial place, in public place

(d) Means of injury

(e) Signature Norman J. Cole, M.D.

Address 4940 Eastern Ave. Date signed 8/8/48

PHYSICIAN

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 65747

BC = 3 18671

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
State
County
Balto.,
Street No. 0 for

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex F

5. Color or race C

6. Single, married, widowed or divorced

6 b. Name of husband or wife

6 c. If married, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 3 | Months | Days | If less than one day, hrs. or min.

9. Birthplace Balto. Md
(town, county and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Bernice [illegible]

13. Birthplace North Carolina

MOTHER 14. Maiden Name Helen [illegible]

15. Birthplace Baltimore, Md.

16 (a) Informant Helen Wilson

(b) Address 541 Oxford St

17 (a) Burial, cremation or removal Burial

(b) Date then Aug 6 47

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director Elroy B. Watson

(b) Address 1340 Braunton Rd

19 (a) [illegible] Hunting for Baltimore, Md

(b) Date registered

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1947 at 8:40 P.M.

21. I certify that I took charge of the remains of the above named deceased on Aug. 7, 1947 and that I last saw deceased alive on Aug. 7, 1947 and that death occurred on the date stated above at 8:40 P.M. The cause of death and the sequence of conditions leading to death were:

Autopsy (Yes or No) Yes

Inq. & Inquiry (Before completing this section see instructions on reverse side)

Autopsy findings will be forwarded

IMMEDIATE CAUSE OF DEATH Fractured Skull,

Due to

Due to

Due to

22. If an external cause was involved, state how injury occurred, whether accidental, suicidal or homicidal, and describe fully the circumstances.

Date of injury Aug. 7, 1947 Approx. time 8:40 P.M.

Where injury occurred 0 Oxford St

Did injury occur in or about home, factory, office, farm, street, etc.

Specify

Was injury work connected

Manner of injury

Signature [illegible] M.D.

Date signed Aug 9 1947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65748

65748

1 PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 136 W. West St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2 USUAL RESIDENCE OF DECEASED
State Md. County
City or town Baltimore
Street No. 136 W. West Street
(a) Citizen of (country) (Yes or No)
If yes, name of city

3 (a) FULL NAME Mattie Brogden (Bradgen)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race C
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Charles Brogden
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1908
8 AGE: Yrs. 40 Months 11 Days
If less than one day, hrs. or min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

12. Name of father Edward Parker
13. Birthplace of father Virginia
14. Maiden name of mother Mary Matthews
15. Birthplace of mother Maryland

16 (a) Informant Ella Phillips (S)
(b) Address 708 Hanover Street

17. Burial, cremation, or removal
(a) Cemetery or crematory Mt. Calvary
Location Mt. Calvary Road
18 (a) Funeral director Leonard L. Wise
(b) Address 1520 Montgomery St.
19. Filed AUG 10 1948 Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH August 9, 1948 at 4:35 M

21. I certify that I knew the person described above and that death occurred at the time stated above. The cause of death was ascertained from personal observation and from the evidence obtained by said Attendant. Inspection of the body and that said deceased came to her death at the time stated above, and death in my opinion resulted from natural causes. Accident, suicide, homicide (state circumstances) and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion
due to Chronic Congestive Heart Failure

M.D.
Medical Examiner
Signed Aug. 10, 1948

VS 15

65749

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

65749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

65749
Registered No.

1 PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Pearl Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2 USUAL RESIDENCE OF DECEASED
(a) State Md County
(b) City or town Baltimore
(c) Street No 14 N Pearl St
(d) Citizen of [illegible] country? Yes or No
If yes, name country

3 (a) FULL NAME Allen O'Brien

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex male | 5 Color or race white | 6 (a) Single, married, widowed, or divorced divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Date of death (mo. day, yr.) July 21, 1948

8. AGE: Years 58 | Months | Days | If less than one day, hr. min.

9. Birthplace West Virginia (Town, city, and state)

10. Usual Occupation

11. Industry or business

FATHER
12 Name Hezekiah O'Brien
13 Birthplace West Virginia

MOTHER
14 Maiden Name
15. Birthplace West Virginia

16 (a) Informant Mrs. Dodd
(b) Address Webster Springs W. Va

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 29, 48

(c) Cemetery or crematory location Webster Springs, W. Va

18 (a) Funeral director Stacy W. Wiltse
Address 401 Fairmount Ave Baltimore Md

(b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1948 at 1:40 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy (Inspection) (Inquest) and that said deceased came to death on the day stated above, and death in my opinion resulted from natural causes, accident, suicide, homicide (suicide or homicide?), and that the causes of death were

IMMEDIATE CAUSE OF DEATH
(a) Cerebral Hemorrhage

Due to

Other significant conditions

22. If a female: (a) Pregnant at time of death, (b) Pregnant within three months preceding death, (c) Date of delivery

(d) Autopsy

Did operation precede death?

Were any findings of operation available to you in completing this certificate?

(e) Medical examiner

23. Signature [illegible] M.D.

Date signed July 29, 1948

VII 161

VII 161

665750

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

665750

1. PLACE OF DEATH.
(a) Baltimore City, Maryland
(b) Street address 1231 Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Born

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No 1231 Hanover St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3. (a) FULL NAME Peter J McGinnis
(b) If veteran, name war No
(c) Social Security Account No

4. Sex Male
5. Color or race White
6. (a) Single, married, wid., wd., or divorced Widower
(b) Name of husband or wife Lucia A McGinnis
(c) If widow, give age 71 years

7. Birth date of deceased mo. day yr. March 21 1877
8. AGE: Years 70 Months 4 Days 10 (If less than one day) hr. min.
9. Birthplace Queenstown Md
(Town, county and state)
10. Usual Occupation Retired Fireman
11. Industry or business Fire Dept. Balto
12. Name John Jos McGinnis
13. Birthplace Ireland
14. Maiden Name Margaret Foley
15. Birthplace Ireland
16. (a) Informant Mrs. Lucia A McGinnis
(b) Address 1231 Hanover St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof
(c) Cemetery or crematory Loudon Park
Location Balto Md
18. (a) Funeral director C H Jenkins & Co
(b) Address 1231 Hanover St
19. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24, 1948 at 10 M
I certify that death occurred on the date above stated, that I attended deceased from May 24 1948 to Aug 9 1948 and that I last saw h[illegible] alive on Aug 9 1948.
Immediate cause of death
Coronary Thrombosis
Due to Arteriosclerosis
Due to
Other Conditions
Duration

PHYSICIAN
Underline the name to which death should be charged statistically

Date of operation
Major findings of operation
Was autopsy
20. Were there any external causes, (1) on the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, or in industrial place or in public place? While at work
(e) Means of injury
23. Signature Denis J. Gratton
Address 1231 Randall St Date signed 5/10/48

VS 170

6657:51

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Register No. 6657:51

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Avenue
(c) Hospital or institution Ardleigh Nursing Home
(d) Length of stay in hospital or institution, yrs., mos., or days
(e) Length of stay in Baltimore, yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore
(d) Street address 2540 Beryl Avenue
(e) Inside city limits? Yes No

3 (a) FULL NAME Louis Joseph Soul, Sr.
3 (b) If veteran, name war
4. Social Security Account No.
4. Sex Male
5. Color or race White
6. If Single, married, widowed, or divorced Widowed
6 (a) Name of husband or wife Mary (nee Blazek)
6 (b) If child, give age years
7. Birth date of deceased (mo., day, yr.) June 20, 1880
8. AGE: Years 68 Months Days If less than one day hrs. min.
9. Birthplace Czechoslovakia (Town, county or state)
10. Usual Occupation retired
11. Industry or business

FATHER

12. Name John Soul
13. Birthplace Czechoslovakia

MOTHER

14. Maiden Name unknown
15. Birthplace "

16. (a) Informant Mrs. Clara Joy - daughter
(b) Address 2640 Beryl Avenue
17. (a) Burial, cremation or removal Burial (b) Date of burial, cremation or removal 8/. 2/ 48
(c) Cemetery or crematory Holy Redeemer Location 4430 Belair Rd. Baltimore, Md.
18. (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street
19. (a) Date received by local registrar AUG 10 1948 (b) Signature of local registrar Thomas J. Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1948 at 6:50 P.M.
21. I attended the deceased from July 23 1948 to August 9 1948
I last saw the deceased alive on August 9 1948
Immediate cause of death — Duration

Due to: Metastatic carcinoma
Due to: Gastric neoplasm
Due to: Auricular fibrillation
Other significant conditions contributing to death but not related to terminal disease conditions: Cardiac decompensation

Date of operation
Major findings of operation

PHYSICIAN

I saw the deceased on the dates given above. To the best of my knowledge, death occurred at the time, date and place, and due to the cause stated.

Signature Joseph C. Statchar
Address 3831 Juneway Rd. Aug 10, 1948

VS 19

65752
10-12-1899

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH F E E

Registered No. 65752

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1040 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst.: yrs., mos., or days 3days
(e) Length of stay in Baltimore: yrs., mos., or days Life

2. USUAL RESIDENCE OF DECEASED
State Md. County Baltimore
City or town Essex
Street No. 311 Stillwater Ave.
Citizen of what country? Yrs. in U.S.
If yes, name country

3. (a) FULL NAME Joseph John Weinhold
(b) If veteran, war
(c) Social Security Account No.

4. Sex M
5. Color or race W
6. Single, married, widowed or divorced Married
(b) Name of husband or wife Anna Rupp Weinhold
If married, widowed or divorced, give age
7. Birth date of deceased (Month, Day, Year) Feb. 11- 1882
8. AGE: Years 66 Months Days If less than one day, hrs. or min.
9. Birthplace Md. Baltimore (Town, county or state)
10. Usual Occupation ? Bricklayer
11. Industry or business Novak Realty Co.

FATHER
12. Name John Henry Weinhold
13. Birthplace ? Baltimore, Md.

MOTHER
14. Maiden Name Anna Pocot
15. Birthplace Md.

16. (a) Informant Mrs. Maris Rabb - daughter
(b) Address 457 Drew Street, Balto - 24 - Md.

17. (a) Burial (Burial, cremation, or removal)
(b) Date thereof 8/13/48 (Month, Day, Year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd.

18. (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

AUG 10 1948 Huntington for Williams, M.D.
Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9- 48 11A M
21. I attended deceased from 8-6- 48 to 8-9- 48
I last saw him 8-7- 48
Immediate cause of death (a) Hypernephroma
(b) Pulmonary terminal
Duration 2 mos
1 day
Other significant conditions contributing to death but not related to the terminal
PHYSICIAN
Date of operation
Major findings of operation
of autopsy
If death was due to external causes (violence) fill in the following
Accident, suicide or homicide
(b) Date of occurrence at M
Where did injury occur?
Did injury occur while at work in public place? While at work
Means of injury
23. Signature M. J. Nelson
Address Date signed 8/9/48

VS 5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 665753

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Dulaney Ave.
(c) Hospital or institution
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECREASED:
a State Md b County
c City or town (If outside city or town limits, write R.F.D. and give town)
d Street No. 3rd Chesapeake Springs
(If rural, give location)
(e) Citizen of foreign country? Yes or No?
If yes, name country

3 (a) FULL NAME Benjamin Dove
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6. Single, married, widowed, or divorced Widowed
6 (a) Name of husband or wife Lawrence
6 (b) If alive, give age years

7. Birth date of deceased mo., day, yr. Aug
8. AGE: Years 76 | Months 7 | Days | If less than one day hr min

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Boiler Washer
11. Industry or business Dyer

FATHER
12. Name B. Franklin Dove
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Anne Humphreys
15. Birthplace Maryland

16 (a) Informant Mrs. Lawrence Dove
(b) Address 18 S. Eutaw Ave Arnoldpark

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director
(b) Address

19 (a) (b) Registrar

MEDICAL CERTIFICATION

20 DATE OF DEATH 8/9 19 48, 3:30 P.M.

21. I certify that I attended the deceased from 6/27 19 48 to 8/9 19 48
I last saw the deceased alive on 8/7 19 48

Immediate cause of death Coronary Occlusion
Heart failure

Due to Coronary thrombosis, multiple embolic

Due to Pneumonia bilateral

Other Conditions Arteriosclerosis

Erratum

Date of operation June 21, 1945
Major findings of operation: Fibroid
of autopsy: no abstract

PHYSICIAN
Under the rules which death should be charged (statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(c) Date of occurrence at M.
(d) Where did injury occur? (City, town or county) (State)
(e) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(f) Means of injury

23. Signature Frank Dwyer Jr. M.D.
Address St Agnes Hospital Baltimore Md. Date signed 8-9-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65754

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ...
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) ...

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County ...
(b) City or town Baltimore
(If outside city or town, write RFD and give town)
(d) Street No. 1925 W. Fayette St.
(If rural, give location)
(e) Citizen of foreign country? Yes or No
If yes, name country ...

3 (a) FULL NAME John Albert WESTLAKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife ...

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) ...

8. AGE: Years: 57 | Months | Days | If less than one day: hr ... min

9. Birthplace ... (Town, county, and state)

10. Usual Occupation ...

11. Industry or business ...

12. Name ...

13. Birthplace ...

14. Maiden Name ...

15. Birthplace ...

16 (a) Informant ...

(b) Address ...

17 (a) ... (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory ...

Location ... AUG 10 1948 Commissioner of Health

18 (a) Funeral director ...

(b) Address ...

19 (c) AUG 10 1948 (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1948, at 7.43 P M

21. I certify that I took charge of the remains described above and an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to ... his death on the day stated above, and death in my opinion resulted from natural causes, accident ..., suicide ..., homicide ..., undetermined ..., and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Syphilitic aortitis
Fatty degeneration of liver.

Due to ...

Other Conditions ...

(Include pregnancy within 3 months of death)

22. If an external cause was present, whether accident, suicide or homicide, cause of death, fill in the following:

(a) Date of injury ... at ... M.

(b) Where did injury occur?

(c) Did injury occur in or about home, factory, street, office building, or other public place? ... What was he doing?

(d) Means of injury ...

23. Signature ... M.D.
Medical Examiner

Date signed 7/21/48

VS 181

BALTIMORE CITY HEALTH DEPARTMENT G65255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65755

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) ~~Hospital~~ or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(c) City or town Glen Burnie,
(If outside city or town limits, write RURAL and name county)
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Boy Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Baltimore Medical School AUG 10 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) AUG 10 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 851

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2, 1948 at 11:05 M.

21. I certify that I took charge of the remains of the deceased above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death was in my opinion resulted from: natural causes ✓, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Lobar pneumonia, left lung

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary or secondary in the cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, in factory, while at work, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner

Date signed 8/3/48

56 BALTIMORE CITY HEALTH DEPARTMENT G65756

MB121752 CERTIFICATE OF DEATH 1/2 B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life (51 yrs)

2. USUAL RESIDENCE OF DECEASED:
a State Md. b County
c City or town Baltimore
If outside city or town limits, write RFD and name of town
d Street No. 1028 Denver st.
e Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Elmer Leitch
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6. (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Margaret Stansbury
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Oct. 12, 1896

8. AGE: Years 51 | Months 9 | Days 20 24 | If less than one day hr min

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Roofer - Painter
11. Industry or business Own Business

FATHER
12. Name Ernest Leitch
13. Birthplace Md

MOTHER
14. Maiden Name Alice Coursey
15. Birthplace Md

16 (a) Informant Records - Balto. City Hospitals
(b) Address 4940 EasternAve.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St Paul st.

19 AUG 11 1948 (Date received by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10-48 at 8:46 A.M. M

21. I certify that I attended the deceased from 8-2-48 to 8-10-48 and that I last saw him alive on 8-10 48

Immediate cause of death Pulmonary tuberculosis

Duration 5-10 yr

Due to

Due to

Other Conditions

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

In giving the cause from which death is to be charged state specifically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(d) Did injury occur about home, on farm, industrial place, in public place, or while at work?
(e) Nature of injury

23. Signature Gayle Burton
Address Baltimore City Hospitals Date signed 8/16/48

VS 199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. GE 5757

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2023 Eutaw Place #7
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) less than 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or suburban limits, write RURAL and give town)
Street 2023 Eutaw Pl
City Baltimore
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DELNOSE BOTSFORD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Race: W

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Harold C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 27 1902

8. AGE: Years: 42 Months: 11 Days: 11 If less than one day: hr. min.

9. Birthplace: Chicago Ill (Town, county, and state)

10. Usual Occupation: Telephone operator

11. Industry or business

12. Name: Florence M Marshall

13. Birthplace

14. Maiden Name: Mary A Bennett

15. Birthplace

16 (a) Informant: Mrs Ethel Hemmelmann

(b) Address: 42 S Oakley Ave Highland Park Ill

17 (a) Burial, cremation, removal (b) Date thereof 8/11/45 (month) (day) (year)

(c) Cemetery or crematory: Green mount Cem

Location: Balto

18 (a) Funeral director: Wm Cole Sons

(b) Address: 1217 N Charles St

19 AUG 11 1945 (b) Signature: Wm Williamson M.D. Registrar

(Date filed) (Registrar)

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 1945 at 7.55 M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/2/45 to 8/6/45 and that I last saw h alive on 8/6 1945

IMMEDIATE CAUSE OF DEATH
(a) overwhelming SBC (Miliary spread)
DUE TO
(b) Pleural effusion (involvement)
Due to adrenal, renal, etc. (involvement)
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Duration

of autopsy miliary SBC

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Silverstein

Address Sinai Hospital Baltimore Md Date signed 8/8/45

5758

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 467

Registered No. G65758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Enroute in ambulance
(b) Street address to University Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County Balto
(c) City or town Fullerton, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Klein Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3. (a) FULL NAME Watson Grymes

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-9293

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Laura

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Paperhanger

11. Industry or business

FATHER
12. Name John S. Watson
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Tates
15. Birthplace Va.

16 (a) Informant Mrs. Watson Grymes
(b) Address Klein Ave., Fullerton, Md.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 8, 13 48 (month) (day) (year)

(c) Cemetery or crematory Campbell Memorial
Location Elams, Lancaster Co Va

18 (a) Funeral director Lancaster Funeral Home
(b) Address 7 S ... Main ... Va

AUG 11 1948
(Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1948, at 4 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 6-11 1948 to 8-11 1948 and that I last saw h[illegible] alive on 8-12 1948.

Immediate cause of death
Ruptured tubal pregnancy — Duration

Due to Internal shock

Due to Laparotomy

Other conditions Anemia, acute
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Laparotomy

of autopsy:

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, or public place? (While at work)
(d) Means of injury

23. Signature Robert C Hamilton M.D.
Address Fullerton Md. Date signed 8-10

PHYSICIAN
Underline the cause to which death should be charged statistically

VS 190

5759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G65759

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 S Madeira St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 S Madeira St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antone Chudy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Steel Co.

FATHER
12. Name Peter Chudy
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Frances Chudy
(b) Address 124 S Madeira St

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Aug 13/48 (month) (day) (year)
(c) Cemetery or crematory Holy Sepulchre Cemetery
Location Baltimore

18 (a) Funeral director Fred W Ozazewski
(b) Address 1930 East Fort Ave Baltimore, Md.

AUG 11 1948 (Date rec'd by registrar)

Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9 1948, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-Respiratory Failure

Due to Coronary Heart Disease

Other Conditions Active tuberculosis generalized
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert F. Menaker M.D.
Medical Examiner

Date signed 8-9-48

G65760

AB-103562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G65760

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Dovers St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Margaret Kilper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1-1875

8. AGE: Years 73 | Months 0 | Days 6 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Frederick Kilper
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG 12 '48 (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location Edmondson Ave - Longwood

18 (a) Funeral director Harry H Wright
(b) Address 4101 Edmondson Ave

AUG 11 1948 (b) Wright-Williams Co
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Aug. 10- 19 48 at 6.20 M

21. I certify that deceased was on the date above stated that attended deceased from 8-7- 19 46 to 8-10- 19 48, and that I last saw deceased alive on 8-10-48

Immediate cause of death	Duration
Cerebrovascular Accident	24 hours
Due to	
Due to	
Other Conditions Hypertensive Heart Disease	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause for which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature John Reichold
Address Balt. City Hosp. Date signed 8/10/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 157E

Registered No. G65761

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts.
(c) Hospital or institution: Hospital for the Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Wayne Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Boy Harris Donn robert harris

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8, 1948

8. AGE: Years | Months | Days 2½ | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business —

12. Name Donald Joseph Harris

13. Birthplace Baltimore, Md.

14. Maiden Name Rebecca Louise Muller

15. Birthplace Statesville N. Carolina

16 (a) Informant Mrs. Donald J. Harris

(b) Address 3020 Wayne Ave, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11, 1948 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery

Location Woodlawn, Md.

18 (a) Funeral director E. W. Pennington

(b) Address 4510 Liberty Heights Ave.

19 AUG 11 1948 (Date rec'd by registrar) (b) Huntington Millington M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1948, at 10 08 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8, 1948. to Aug. 10, 1948. and that I last saw him alive on Aug. 10, 1948.

Immediate cause of death Pneumonia — Duration over

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Report will be sent later

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William G. Spencer, Jr. M.D.

Address Hosp. for Women of Md. Date signed 8-11-48

VS 150

65762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 65762

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Linden Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write R.F.D., and give town)
(d) Street No. 1208 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE W. F. WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-9342

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Married

6 (b) Name of husband or wife Nora G. Wilson
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) September 30, 1887

8. AGE: Years	Months	Days	If less than one day
60 6t	10	10	hr. min.

9. Birthplace Turner Station, Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation Painter
11. Industry or business Self

12. Name John Thomas Wilson
13. Birthplace Maryland

14. Maiden Name Lottie M. Proctor
15. Birthplace Maryland

16 (a) Informant Mr. John T. Wilson
(b) Address 3939 Flowerton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11, 1948 (month) (day)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director [illegible]
(b) Address 1003 W. Baltimore St.

AUG 11 1948 [illegible]
(Date received by Registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1948 at 8 A. M.

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
coronary heart disease

Due to

Other Conditions

(Include pertinent complications and duration between onset and death)

22. If an external cause was primary or secondary to disease or other cause of death, fill in the following
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? Was it [illegible]
(d) Means of injury

23. Signature C. F. Blanchard M.D.
Medical Examiner.
Date signed 8/10/48

VS 151

5763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1632

Registered No. G65763

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 St. Paul St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Justina Lutz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Seperated

6 (b) Name of husband or wife: ?

6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.) March 19, 1911

8. AGE: Years: 37 | Months: 4 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Typist

11. Industry or business

12. Name: Edward Wagner

13. Birthplace: Balto.

14. Maiden Name: Justina Habel

15. Birthplace: Balto.

16 (a) Informant: Mrs. J. Holl (sister)
(b) Address: 613 S. Ellwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/1948 (month)
(c) Cemetery or crematory: Sacred Heart Cem.
Location: German Hill Road

18 (a) Funeral director: Lilly & Zeiler Inc.
(b) Address: 403 South Wolfe Street

AUG 11 1948 (Date rec'd by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1948, at 1.20 P M

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Barbiturate poisoning

Due to:

Other Conditions:

(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-4-48 at approx. 2.30 PM
(b) Where did injury occur? 712 St. Paul St.
(c) Did injury occur at home, on farm, industrial place, in public place? home (While at work?) no
(d) Means of injury: Ingestion of sleeping pills

23. Signature: [illegible] M.D. (Medical Examiner)
Date signed 8/9/48

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 665769

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Fairmount & Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL or name of town)
(d) Street No. 5812 Bland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Meyer Shulman

3 (b) If veteran, name war: 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	6 (b) Name of husband or wife	6 (c) If alive, give age
Male	White	Widowed	Jane	years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
58				

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: —

11. Industry or business:

FATHER
12. Name: Jacob
13. Birthplace: Russia

MOTHER
14. Maiden Name: Lilly
15. Birthplace: Russia

16 (a) Informant: Mrs. E. Meyer
(b) Address: 2812 Bland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-48 (month) (day) (year)
(c) Cemetery or crematory: Shaare Tefiloh
Location: Druid Hill Road

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2600 Eastern Ave

19 (a) AUG 11 1948 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10 1948 at 11:10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/6 1948 to 8/10 1948, and that I last saw him alive on 8/10 48.

Immediate cause of death: Cerebrovascular Hemorrhage — Duration

Due to: Arteriosclerosis & Hypertension

Due to:

Other Conditions: Right lower lobe Pneumonia
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Sinai

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Bernard Fabbe
Address: Sinai Hosp. Date signed 8/10/48

V9 150

83a

5765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Register No. 665765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 N. Vincent St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Katherine Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1931

8. AGE: Years 17 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Lee
13. Birthplace Waterbury Md.

MOTHER
14. Maiden Name Leonia Brown
15. Birthplace Hamonds, Md.

16. (a) Informant Mr. & Mrs. Robert Lee.
(b) Address 507 N. Vincent St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11, 1948 (month, day, year)
(c) Cemetery or crematory Mt. Auburn.
Location

18 (a) Funeral director Thos. Kyle R. Williams
(b) Address 324 N. Schroeder St.

AUG 11 1948 (Date rec'd by registrar)

(b) Thos. Kyle Williams, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1948, 1:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Crushed Skull

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary [X] or contributing [ ] cause of death, fill in the following:
(a) Date of injury August 7, 1948
(b) Where did injury occur? Hammond Ferry Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? B & O. overpass (While at work?) No
(d) Means of injury: Car went over the overpass

23. Signature [illegible] M.D.
Medical Examiner
Date signed Aug 7 '48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 665766

665766

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1219 Lyndon Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Lyndon Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME John W Kell

3 (b) U. S. veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Adelaide
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22nd 1868

8. AGE: Years 80 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Alexandria Va.
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business Laborer

INFORMATION FURNISHED BY
12. Name John Kell
13. Birthplace Va

INFORMATION FURNISHED BY
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Mrs. Almeda Meehan
(b) Address 1219 Lyndon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson & Longwood Sts

18 (a) Funeral director John J Gaughan & Son
(b) Address 901-03 Mullins St

19 (a) Aug 11 1948 (Date received by registrar) (b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9th 1948 at 7.32 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1948 to Aug 9 1948, and that I last saw him alive on Aug 9 1948.

Immediate cause of death	Duration
Myocarditis Chronic and myocardial degeneration	6 months
Due to Hypertensive Cardiovascular Renal Arteriosclerosis	6 yr.
Due to Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich Jr M. D.
Address 1227 Madison Ave Date signed 8/10/48

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. G65767

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 Fawn St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-2
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Fawn St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANGELA BERTORELLI

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife late Giovanni
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15 1870

8. AGE: Years 87 | Months 10 | Days 24 23 | If less than one day hr.

9. Birthplace Orsogna Prov. Italy (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name Paolo Iperoni
13. Birthplace Italy

MOTHER
14. Maiden Name Domenica Pagassi
15. Birthplace Italy

16 (a) Informant Luigi Piantelli (Daughter)
(b) Address 1008 Fawn St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 522 S. High St.

AUG 11 1948 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8-48 19 , at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22-48 19 , to 8-8-48 19 , and that I last saw h alive on 8-6-48 19 .

Immediate cause of death Carcinoma of bladder — Duration 10 mos

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 8 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature John Gotantino, M.D.
Address 230 S Conkling St Date signed 8-10-48

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G65768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G65768

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 S. High St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 207 S. High St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Frances Citrano

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25 1861

8. AGE: Years 86 | Months 7 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Cefalu Italy
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

12. Name of father Joseph Citrano

13. Birthplace Italy

14. Maiden Name of mother Concetta Fitarra

15. Birthplace Italy

16 (a) Informant Sarah [illegible] (Sister)

(b) Address 207 S. High St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Dello Russo

(b) Address 328 S. High St.

19 (a) AUG 1 1948 (Date received by registrar) (b) [illegible]

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MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9 1948, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1948 to Aug 9 1948 and that I last saw [illegible] alive on Aug 9 1948

Immediate cause of death: Cardiac failure — Duration

Due to Chronic Nephritis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Scaquetti M. D.

Address 1724 W Lombard St Date signed Aug 10 '48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G65769

85769

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 472 Manse Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) FULL NAME Geneva Bussie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Albert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-05

8. AGE: Years 42 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Lewis
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Harper
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12, 1949 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winder, Md.

18 (a) Funeral director Charles H. Alexander
(b) Address 1200 McCulloh St., Baltimore, Md.

8/9 1949 (Date received by registrar) [illegible] (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1949, at 9 08 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1948 to 8/9 1949 and that I last saw her alive on 8/9 1949.

Immediate cause of death: Uremia — Duration: days

Due to: Anuria — days

Due to: Bulbar Paralysis — days

Other Conditions: Hypertensive cardio-vascular dis. Prostatic obstruction. — years

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: No autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony J. Iezzo M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

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G65770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G65770
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 E. 20th. St.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 E. 20th. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Jane Smith

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James B. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 26, 1862

8. AGE: Years 86 Months 3 Days 14 If less than one day: hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual Occupation: Housewife,
11. Industry or business: at home

FATHER: 12. Name: James Kelly,
13. Birthplace: Ireland,

MOTHER: 14. Maiden Name: Brigid O'Brien,
15. Birthplace: Ireland.

16 (a) Informant: Miss Helen Smith,
(b) Address: 521 E. 20th. St.

17 (a) burial (Burial, cremation, or removal)
(b) Date thereof 8/13/48 (month) (day) (year)
(c) Cemetery or crematory: Cathedral Cem.
Location: Baltimore, Md.

18 (a) Funeral director: C. Vernon Lemmon
(b) Address: 4611 Park Heights Ave.

(Date received by registrar) (b)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1948, at 9-- A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 to 8/10 1948.
and that I last saw h alive on 8/10 19 48

Immediate cause of death

Congestive Heart Failure — Duration: 6 weeks
Due to Arteriosclerotic Cardio-Vascular Disease — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Fearley M. D.
Address 11 East Chase St. Date signed

X

G65771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

G65771 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison
(c) Hospital or institution: 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Lanier (Jane Lanier)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10 1893

8. AGE: Years 55 | Months 1 | Days — | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

12. Name of husband Unknown

13. Birthplace Unknown

14. Maiden Name Unknown

15. Birthplace Unknown

16. (a) Informant Mrs. Lanier

(b) Address 1127 W. Lubbery Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13, 1948 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn Cemetery

Location Baltimore City

18. (a) Funeral director Hans L. Gude Sons

(b) Address 1121 Hanover Street

(Signature of undertaker or person acting as such)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10 1948, at 12 M

21. I certify that death occurred on the date above stated, that I attended deceased from 6/ 1948 to 8/10 1948 and that I last saw h[illegible] alive on 8/7 1948

Immediate cause of death: Cerebral Hemorrhage — Duration 2 years

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. [illegible] M. D.

Address 1000 Madison St. Date signed 8/11

GS 150

665772 ✓ 665772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 Madeira ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 - Warren Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Mullins
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	col	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/4/1863

8. AGE: Years 84 | Months 5 | Days 3 | If less than one day hrs. min.

9. Birthplace Mary Land
(Town, county, and state)

10. Usual Occupation
11. Industry or business

12. Name of father Unknown
13. Birthplace of father Unknown

14. Maiden Name of mother Unknown
15. Birthplace of mother Unknown

16 (a) Informant Attendant Wil Bar Home
(b) Address 1217 Madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 10 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Baltimore City

18 (a) Funeral director Joseph A. Bailey
(b) Address 1700 West Lanvale Street

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/7 1948 at 5:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 7/15 1948 to 8/7 1948 and that I last saw h alive on 8/6 1948

Immediate cause of death	Duration
Uremia Cardiac Hypertension Renal disease	2 yrs
Due to Arterio Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. C. Carlson M.D.
Address 1500 Linden Ave Baltimore 17, Md

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G65773

G65773

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 733 W HAMBURG ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 733 W. HAMBURG ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN M. SCOTT

3 (b) If veteran, name war –

3 (c) Social Security Account No. 213-01-0499

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife DOROTHY SCOTT

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) NOV-15-1892

8. AGE: Years 55 | Months 8 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation GLASS WORKER.

11. Industry or business BUCK GLASS Co.

FATHER 12. Name JOHN B SCOTT

13. Birthplace SCOTLAND

MOTHER 14. Maiden Name ALICE McCAEAN

15 Birthplace MARYLAND

16 (a) Informant DOROTHY SCOTT

(b) Address 733 W HAMBURG ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-13-48 (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS CEM A. A Co.

Location

18 (a) Funeral director Bernard E Hartz

(b) Address 121 E WEST ST.

19 (a) ..... (Date received) (b) ..... (Registrar)

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MEDICAL CERTIFICATION

26. DATE OF DEATH AUG. 11 1948, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1948 to Aug 11 1948 and that I last saw him alive on Aug 11 1948

Immediate cause of death Carcinoma, Lung — Duration .....

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation July 1948

Major findings of operation: Carcinoma left lung,

of autopsy: .....

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Francis L. Greenstein M.D.

Address 2301 Annapolis Rd. Md 30 Date signed Aug 14 48

G655774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G655774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 N. Fremont ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Serio, Concetta

3 (b) If veteran, name war →

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife: Vincent Serio
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) May 11, 1887

8. AGE: Years	Months	Days	If less than one day
61	2	29	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

12. Name of informant Samuel Serio
13. Birthplace Italy
14. Maiden name of wife Catherine Rotolia
15. Birthplace Italy
16 (a) Informant MRS Sal Serio
(b) Address 520 N. Fremont Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13/1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location (Baltimore)
18 (a) Funeral director Frederick J. Cole
(b) Address 1211 W. Lombard St.
19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-9-1948, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-20 1948 to 8-9 1948, and that I last saw her alive on 8-9 1948.

Immediate cause of death Meningitis (organism undetermined) — Duration: 4 weeks

Due to Kidney carbuncle, left — Duration: approx same

Due to Cerebral thrombosis, left. — Duration: 3 weeks

Other Conditions Hypertension C.V.D. Arteriosclerosis — Duration: unknown
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Was autopsy? None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marie D. Davis
Address W. Balto. Gen. Hosp. Date signed 6-9-48

VS 110

G65775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G65775 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6903 Henderson Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12

(e) Length of stay in Baltimore (yrs., mos., or days) 58 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6903 Henderson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE H. GERMETEN

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband [illegible]: Phillip H. Germeten

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1889

8. AGE: Years 58 | Months 0 | Days 20 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Rudolph Schmitt
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Henry J. Germeten
(b) Address 3913 Ednor Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/48 (month) (day) (year)
(c) Cemetery Lorraine Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md

19 (a) [illegible] (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9, 1948, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1947 to Aug 9 1948.
and that I last saw him alive on Aug 8 1948

Immediate cause of death: Cerebral Hemorrhage — Duration 4 days

Due to Cerebral Arteriosclerosis — 4 yrs

Due to Hypertension — 4 yrs

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature A. J. Charlton M. D.
Address 1610 York Rd. Date signed Aug 10 48

G65776

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G65776
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 645 Harvey St.
(c) Hospital or institution:

24 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 645 Harvey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MOLLIE V. MUNDIE

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 218-14-6121

4. Sex	5. Color or race	5 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband ~~or wife~~ Joshua R. Mundie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	3	10		

9. Birthplace Baltimore Md. (City, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John E. Higgins
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Eliza Dorsey
15. Birthplace Balto. Md.

16 (a) Informant Mr. J. R. Mundie
(b) Address 645 Harvey St. 39

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Immanuel Cem.
Location Manchester, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

AUG 11 1948
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1948 1:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Aug 10 1948. and that I last saw her alive on Aug 10 1948.

Immediate cause of death Respiratory failure

Due to Carcinoma of breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Shorofsky M.D.
Address 601 N. Monroe St. Date signed Aug 11, 48 M. D.

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G65777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65777 46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) /
(e) Length of stay in Baltimore (yrs., mos., or days) /

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Edgemont Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Sergeant Hyson

3 (b) If veteran, name war: I World War
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothy V. Hyson
6 (c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): March 16 1898

8. AGE: Years: 50 | Months: 4 | Days: 25 | If less than one day: hr. / min.

9. Birthplace: Hampstead, Carroll Co. Md (Town, county, and state)

10. Usual Occupation: Supt. Balto. Co. Schools
11. Industry or business: Education

FATHER
12. Name: David Hyson
13. Birthplace: Hanoverstown Pa.

MOTHER
14. Maiden Name: Clara Perry
15. Birthplace

16 (a) Informant: Dorothy V. Hyson
(b) Address: 112 Edgemont Rd, Towson Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 12 1948 (month) (day) (year)
(c) Cemetery or crematory: Hampstead Cem
Location: Hampstead Md

18 (a) Funeral Director: John G. Moran
(b) Address: 3004 Wells St

19 (a) Filed: AUG 13 1948 (b) Registrar: [signature]

MEDICAL CERTIFICATION

20 DATE OF DEATH: Aug 10 1948, at 9 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1947, to Aug 10 1948, and that I last saw h/m alive on Aug 10 1948

Immediate cause of death: Obstruction of small intestines — Duration: 1 week

Due to: Carcinoma of sigmoid colon & peritoneal metastasis — Duration: 8 mos.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: Nov 29 1947

Major findings of operation: Carcinoma of sigmoid colon & metastases

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: William P. Tilmore, M. D.
Address: 1224 N Charles St Date signed: 8-9-48

G65778 BALTIMORE CITY HEALTH DEPARTMENT G65778
Registered No.

CERTIFICATE OF DEATH 44a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 Light St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Lutz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M.

6 (b) Name of husband or wife Audrey Nelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-11-1905

8. AGE: Years	Months	Days	If less than one day
43	3	—	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Rigger
11. Industry or business Md. Drydock.

12. Name
13. Birthplace
14. Maiden Name
15. Birthplace

16 (a) Informant Family
(b) Address 1834 Light Street.

17 (a) B. (b) Date thereof 8-14-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director James L. McCauley
(b) Address 130 S. Fort Ave.

(c) 8-14-1948 [illegible] Registrar
Date received by registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1948, at 3:26 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If ~~the external cause was primary~~ ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? What was [illegible] doing?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed

G65779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G65779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 Aft Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Aft Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olive B. Lawson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Female	White	Married

6 (b) Name of husband or wife Allen R. Lawson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1897

8. AGE: Years	Months	Days	If less than one day
51	2	3	hr. , min.

9. Birthplace Richmond W. Virginia (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

EMPLOYER

12. Name Clowing Alley
13. Birthplace West Virginia

SURVIVING SPOUSE

14. Maiden Name of Surviving Spouse Amanda Londermilk
15. Birthplace West Virginia

16 (a) Informant Allen R. Lawson
(b) Address 914 Aft Court

17 (a) B (Burial, cremation, or removal) (b) Date thereof 8-13-48 (month) (day) (year)
(c) Cemetery or crematory Redwood
Location Redwood W. Va.

18 (a) Funeral director Lechtenberg Salisbury Funeral Home
(b) Address 317 W. Fayette St. Baltimore 1 Md.

19 (a) Filed 8-11-1948 (b) [illegible] registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1948, at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19 , to — 19 , and that I last saw h[illegible] alive on Aug 9, 19 48.

Immediate cause of death Pulmonary Oedema

Duration

Due to cardiac failure

Due to high blood pressure, Coronary heart disease

13 months,

Other Conditions Contributing Cerebral hemorrhage, hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Imre Newbauer M. D.
Address 936 Patapsco Ave Date signed 8-10-48

VS 2

102

VS 2:

102

G65780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G65780

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1431 West 37th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 -

(e) Length of stay in Baltimore (yrs., mos., or days) 18 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (Country)
(b) City or town Baltimore (If outside city or town limits, write R.F.D. and give town)
(c) Street No. 1431 West 37th Street (If rural, give location)
(g) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence F. Sigler

3 (b) Yesterday, single, married, widowed, or divorced? Veteran #1

3 (c) Social Security Account No. 213-05-0515

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Fannie P. Sigler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30-1891

8. AGE: Years 57 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace Stanley Virginia (Town, county, and state)

10. Usual Occupation Laborer Shipyard Man

11. Industry or business Martin Corp.

FATHER 12. Name Unknown

13. Birthplace Virginia

MOTHER 14. Maiden Name Fannie

15. Birthplace Virginia

16 (a) Informant Mrs. Fannie P. Sigler

(b) Address 1431 W. 37th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12-1978

(c) Cemetery or crematory Lorraine Park

Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home

(b) Address 2231 Falls Road

19 (a) 1948 (Date received by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/78 19 ..., at 2.50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner

Date signed 8/10/78

VS 15:

X

G65781

G65781

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

G65781 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1931 Westheights Ave
(c) Hospital or institution:

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1931 Westheights Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 da
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

3 (a) FULL NAME Howard C. Buffington

3 (b) If veteran, name war. —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Hannah R. Buffington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20 1862

8. AGE: Years 86 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Bird Hill, Carroll Co. Maryland (Town, county, and state)

10. Usual Occupation Foreman Cotton Mill

11. Industry or business Retired 25 years

FATHER 12. Name William Buffington

13. Birthplace Maryland

MOTHER 14. Maiden Name Elizabeth Crabbs

15. Birthplace Maryland

16 (a) Informant N. Lehan Donaldson

(b) Address 705 Montgomery St. Laurel, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12-1948 (month, day, year)

(c) Cemetery or crematory Woodlawn

Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Park Road

Aug 11 1948 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10 1948, at 11:05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature O. F. Blackwell M.D. Medical Examiner.

Date signed 8/10/48

G65782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 75C

Registered No. G65782

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 Division Street.
(c) Hospital or institution: Provident Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 10yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ubrneth Hopkins

3 (b) if veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Savannah Hopkins · 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SAW 18th 1902

8. AGE: Years 43 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace FRANKLIN Virginia
(Town, county, and state)

10. Usual Occupation laborer.

11. Industry or business

FATHER 12. Name Sow Hopkins

13. Birthplace South Hampton, Va.

MOTHER 14. Maiden Name Annie Jones

15. Birthplace South Hampton Va.

16 (a) Informant Hospital Records.

(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary.
Location Baltimore

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave.

19 (a) AUG 11 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3-48 19 , at 11:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26-48 19 , to 8-3-48 19 , and that I last saw h[illegible] alive on 8-2 19 48.

Immediate cause of death Hypostatic Pneumonia
Hepatic & splenic congestion.

Due to Concussion of brain determined chronic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See MH Cause of death

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Amos H. Carter jr. M. D.

Address Provident Hosp Date signed 8-6-48

WE 150

X

G65783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

G65783 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 Vine St.
(c) Hospital or institution 18

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Vine St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leah J. Hollis

3 (b) If veteran, name war No

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/24/1863

8. AGE: Years 84 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Balt. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Samuel Green

13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Williams

15. Birthplace Balt. Md.

16 (a) Informant Mrs. Michael O'Regan (D)

(b) Address 813 Vine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/48 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem'l. Pk.

Location Baltimore County, Md.

18 (a) Funeral director Charles L. Cooper

(b) Address 512 N. Carrollton Ave

19 (a) 8-11-1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8/48 19 , at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/28 to 8/8 1948 and that I last saw h alive on 8/7 1948.

Immediate cause of death: Acute Respiratory Failure — Duration 2 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. N. Hulet M.D.

Address 1 W. Saratoga Date signed 8/9/48

G65784

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 160c

G65784
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 19 Newborn
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 W Lombard St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Lucille Lyons.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-11-48.

8. AGE: Years | Months | Days | If less than one day hr. 2-3 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Maryland W Lyons
13. Birthplace Maryland

MOTHER
14. Maiden Name Evelyn M Harris.
15 Birthplace North Carolina.

16 (a) Informant Father - above.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Thomas & Lemmon
(b) Address 1414 Light St.

19 (a) Date received by registrar 8-11-48 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11-1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11-1948 to 8-11-1948 and that I last saw her alive on 8-11-1948.

Immediate cause of death Fetal Anoxia in utero.
Due to prolapsed cord.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed

G665785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G665785
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3504 Elm Ave
(c) Hospital or institution: 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Elm Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert E Barnes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18 1863

8. AGE: Years 85 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

INFORMANT
12. Name Robert E Barnes
13. Birthplace Md

MOTHER
14. Maiden Name Anne Gamber
15. Birthplace Md

16 (a) Informant Mary C Barnes
(b) Address 3504 Elm Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12 48 (month) (day) (year)
(c) Cemetery or Crematory Providence M. P.
Location Gamber Md

18 (a) Funeral director Frank H Seitz
(b) Address 2014 W Fay

(Signature of registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9th 1948 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1945 to Aug 9th 1948 and that I last saw him alive on Aug 9th 48

Immediate cause of death (a) Cerebral Hemorrhage
(b)
(c)
(d)

Duration 4 yrs

Due to Arteriosclerosis, Senility, Prostate Trouble

Due to Hyp. Hrt.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B A Lilich

Address 3615 Fare. 140 Date signed Aug 10/48 M. D.

VS 150

G65786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65786 X 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 10 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Balto
(c) City or town: Baltimore - Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1931 Crafton ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Kate F Wehr
3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife: Ferdinand Wehr
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): NOV 30 1891

8. AGE: Years	Months	Days	If less than one day
56	8	10	hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: House wife
11. Industry or business

FATHER 12. Name	Frederick Brocklander
13. Birthplace	Baltimore Md.
MOTHER 14. Maiden Name	Margaret
15. Birthplace	

16 (a) Informant: FERDINAND WEHR
(b) Address: 1931 CRAFTON AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: AUG 12 1948 (month) (day) (year)
(c) Cemetery or crematory: OAK LAWN
Location: 7225 EASTERN AVE

18 (a) Funeral director: Roland L. Fischer
(b) Address: 2112 LUNDALE AVE DUNDALK 22 MD

19 (a) (b) Registrar

NB 1 VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/9 1948 at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/31 1948 to 8/9 1948 and that I last saw him alive on 8/9 1948

Immediate cause of death: Cardiac failure
Cerebral vascular accident
Last Seen
Due to: Myocardial degeneration
Due to: Diabetes Mellitus

Duration

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: D W Mertz M. D.
Address: Church Home Date signed: 8/10/48

AB-31482 G65787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G65787
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Aisquith Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Donoghue

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. ?-1860

8. AGE: Years 87 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name John W. Reddall or John W. Riddall
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eleanor Jones
15. Birthplace Baltimore, Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North ave & Rose st

18 (a) Funeral director Clayton Hoffman
(b) Address 1639 Broadway

19 (a) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10- 1948, at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9- 1938, to 8-10- 1948 and that I last saw her alive on 8-10- 1948

Immediate cause of death Cerebrovascular Accident — Duration 19 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allen Barbold, M. D.
Address Balt. City Hosp. Date signed 8/11/48

VS 193

G65788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. 5788

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 220 N. Calvert St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 W. Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? no Yes or No
If yes, name country

3 (a) FULL NAME William O. Thomas Thomason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Lillian J. Thompson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/28/1912

8. AGE: Years 36 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Michigan (Town, county, and state)

10. Usual Occupation Accountant Ratio Examiner

11. Industry or business U.S.G.

FATHER 12. Name Franklin Thomas

13. Birthplace Mich.

MOTHER 14. Maiden Name Grace Brewster

15. Birthplace Mich.

16 (a) Informant Lillian Thomas

(b) Address 7[illegible] West Hills Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13/48 (month, day)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Balto. Co. Md.

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1900 Eutaw Place

19 (a) [illegible] (b) Date registered [illegible]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 1948, at 9[15] AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-10-48 at Approx. 6[15] AM.
(b) Where did injury occur? 220 N. Calvert St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Turning on gas stove

23. Signature Emil R. Rydon M.D.
Medical Examiner.
Date signed 8-10-48

X

865789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G65789

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 N. Spring St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Nichols
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 10, 1880
8. AGE: Years 68 | Months 4 | Days 29 | If less than one day: hr. min.
9. Birthplace (Town, county, and state) Lancaster Co. Va.
10. Usual Occupation Laborer
11. Industry or business Canton R.R.

FATHER
12. Name Robert Nichols
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Lynn
15. Birthplace ?

16 (a) Informant Hospital Records
(b) Address

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 8-12-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Baltimore, Md.

18 (a) Funeral director Holland Funeral Home
(b) Address 1631 Edmondson Ave

19 (a) AUG 1 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1948 at 6.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3- 1948 to 8-8 1948 and that I last saw him alive on 8-8 1948

Immediate cause of death Colonic Abscess Encapsulated Peritonitis — Duration

Due to Ruptured Diverticula of Colon

Due to Splenic and Hepatic Congestion

Other Conditions Pulmonary Congestion and edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Simon P. Carter Jr. M. D.
Address Date signed

Please write the cause of death clearly and legibly.

VS 750

BC-48-11730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registration No. 066730

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2922 Harford Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Calvo

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Aug 7, 1948

8. AGE: Years	Months	Days	If less than one day: hr.	min.
—	—	4		

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Frank Calvo
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret Grassmuck
15. Birthplace Baltimore Md

16 (a) Informant Frank Calvo - Father
(b) Address 2922 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd - Balt. Md
Funeral Della Vone

18 (a) Funeral director
(b) Address 322 S. High St.

19 AUG 11 1948 (Date rec'd by local registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1948, at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1948, to Aug 11 1948, and that I last saw him alive on Aug 11 1948.

Immediate cause of death Respiratory Failure
Mechanical

Due to Hyaline membrane disease

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Fred R. McDaniel Jr. M. D.
Address University Hosp. Date signed 8/11/48

VS 180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65791

G65791

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto. City Hospital
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Chase,
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT MAJOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1942

8. AGE: Years 6 | Months | Days | If less than one day: hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation STUDENT

11. Industry or business

FATHER
12. Name ROBERT MAJOR SR.
13. Birthplace BALTIMORE, MD

MOTHER
14. Maiden Name THAIS JOHNS
15. Birthplace CHASE, MD

16 (a) Informant ROBERT MAJOR SR
(b) Address CHASE, MD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG 12, 1948 (month) (day) (year)
(c) Cemetery or crematory SHARP ST CEMETERY
Location CHASE, MD

18 (a) Funeral director HOLLAND FUNERAL HOME
(b) Address 1631 DRUID HILL AVE

19 (a) AUG 11 1948 (Date received by registrar) Baltimore, Maryland

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1948 at 7:14 P M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Enquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH Concussion of brain, Fracture of right femur

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑, or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-8-48 at Approx. 6:50 P. M.
(b) Where did injury occur? Chase, Maryland (Eastern Avenue)
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped. struck by auto.

23. Signature M.D.
Medical Examiner

Date signed 9 Aug 48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 4612

Registered 665792

665792

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 N. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 N. Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward T. Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-5079

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife M. Pauline Carroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25th 1886

8. AGE: Years	Months	Days	If less than one day
62	5	15	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Edward T. Carroll
13. Birthplace ?

MOTHER
14. Maiden Name Mary B. Gittings
15. Birthplace ?

16 (a) Informant M. Pauline Carroll
(b) Address 523 N. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) AUG 12 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10th 1948 at 7 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-19- 1948 to 8-10- 1948, and that I last saw h.. alive on 8-10- 1948.

Immediate cause of death
Cancer - Stomach
with Metastases

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
6 Mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. B. Ross, Jr. M. D.
Address 448 N. Luzerne Ave. Date signed 8-11-48

V S 150

665793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 665793

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 927 N. Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Della A. Blankenship

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wyatt Blankenship
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 12th 1884

8. AGE: Years: 64 | Months: 2 | Days: 23 | If less than one day: hr. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Hezekiah Forrest
13. Birthplace: Va.

MOTHER
14. Maiden Name: Martha P. Hutson
15. Birthplace: Va.

16 (a) Informant: Wyatt Blankenship
(b) Address: 929 N. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/13/48 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Eastern Ave. Extended

18 (a) Funeral director: William Colt Inc
(b) Address: 1217 St. Paul St

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 9th 1948, at 2 a. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18 1942 to Aug. 8 1948 and that I last saw h. alive on Aug 8 1948.

Immediate cause of death: Cerebral hemorrhage 2
Emphysema 2
Due to Carcinoma Prostate

Due to Hypertensive Cardio-Renal Disease.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: J. F. Lederman M. D.
Address: 32 Forest Park Ave Date signed: Aug 9 1948
Balto 12

8:30a

G65794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G65794

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Nicoll Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Nicoll Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. Warehime

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary R. Warehime
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10th 1867

8. AGE: Years	Months	Days	If less than one day hr.	min.
81	1	0		

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

PARENTS
12. Name Reason F. Warehime
13. Birthplace Pa.

PARENTS
14. Maiden Name Unknown
15. Birthplace Pa

16 (a) Informant Reason F. Warehime
(b) Address Mt. Airy, Md. R.F.D. #3

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory Calvary Methodist
Location Taneytown, Carroll Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 121 N. St. Paul St.

19 (a) [illegible] (b) Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1948 at 1035 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1948 to August 10 1948, and that I last saw h[illegible] alive on August 7 1948

Immediate cause of death	Duration
Multiple cerebral thrombosis	11 days
Due to Cardiac decompensation	2 years.
Due to Arteriosclerosis, generalized severe	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Frederick J. Volkmer M. D.
Address 600 York Road Date signed 8-10-48

G65795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC 48-16727 159

Registered No. G65795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Burgundy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl HARDY ("A") (C)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5th 1948

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Univ. Hosp. Baltimore Maryland (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Bernard Hardy

13. Birthplace Balto Md

MOTHER 14. Maiden Name Ulna Murphy

15. Birthplace Balto Md

16 (a) Informant Bernard Hardy

(b) Address 905 Burgundy st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/48 (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location a. a. Co. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 127 S. Paca st

19 (a) AUG 12 1948 (b) Washington (Date rec'd by Local Reg.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1948, at 2.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5/48 19 8/10/48 19 and that I last saw h alive on 8/10 19 48

Immediate cause of death Pneumonia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred C. Williamson Jr. M. D.

Address Community Hosp. Date signed 8/11/48

VS 150

X

655796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 655796

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 W. 25th St.
(c) Hospital or institution: Sinai Hospital of Baltimore, 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 W. 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Skarbalis

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-3055

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Cecil Anne Skarbalis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23 1903

8. AGE: Years 45 46 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Greece
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business Bar & Restaurant

12. Name Manuel Skarbalis

13. Birthplace Greece

14. Maiden Name (Markaroni)

15. Birthplace "

16 (a) Informant Mrs. Cecil Skarbalis

(b) Address 120 W. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

AUG 12 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1948, at 655 M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 19 48 to Aug. 10 19 48

and that I last saw h IM alive on Aug. 10 19 48

Immediate cause of death

Due to Miliary TBC

Due to

Other Conditions Leukemia?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

TBC -

of autopsy: Microscopic not done yet

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. Silverstein

Address Sinai Hospital Baltimore Date signed 8/11/48

VS 150

Chas. Silverstein X

665797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

665797 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Rural (Joppa) (If outside city or town limits, write RURAL and give town)
(d) Street No. RFD #1 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jessie Mae Bowman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ralph W. Bowman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) oct. 16 1916

8. AGE: Years 31 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER 12. Name John Hamilton
13. Birthplace Kentucky

MOTHER 14. Maiden Name Minnie Baldwin
15. Birthplace Georgia

16 (a) Informant Ralph W. Bowman
(b) Address R.F.D. # Joppa Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/12/48 (month) (day) (year)
(c) Cemetery or crematory Wellsburg
Location Brook Co. W. Va.

18 (a) Funeral director W. M. Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1948, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 1948 to 8-12 1948, and that I last saw h-- alive on Aug 11 1948.

Immediate cause of death Cardio-resp- Duration
Watery failure
Due to Generalized dropsy
Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. G. Martin M.D.
Address Maryland Gen. Hosp. Date signed 8-12-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 665758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville (If outside city or town limits, write RURAL and give town)
(d) Street No. Falls Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Reber - Florence Viola Reber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harold W. Reber

6 (c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): 1-24-01

8. AGE: Years: 47 | Months: 7 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Pa - Reading (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Joseph [redacted] Baum
13. Birthplace: Pa. - Reading

MOTHER
14. Maiden Name: Sallie Baum
15. Birthplace: Pa. Reading

16 (a) Informant: Ricardo
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month) (day) (year)
(c) Cemetery or crematory: Pleasant View
Location: Lutherville, Md.

18 (a) Funeral director: [redacted] Brooks
(b) Address: Towson, Md.

19 AUG 12 1948 (Date rec'd by registrar) (b) [redacted] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11, 1948 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1948 to Aug 11 1948 and that I last saw her alive on Aug 11 1948

	Duration
Immediate cause of death: Arteriosclerosis	[redacted]
Malignant hypertension	5 days
Uremia	1 year
Due to: Malignant Hypertension	
Due to: Arteriosclerosis	6 years
Other Conditions: -	

(Include pregnancy within 3 months of death)

Date of operation: -

Major findings of operation: -

of autopsy: Arteriosclerosis, Nephrosclerosis, kidneys, heart

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John Ladimer Harvey M. D.
Address: JOHNS HOPKINS HOSPITAL Date signed

G65799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G65799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 308 S. Gilmor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 S. Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Hanley Doyle

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Michael Doyle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 - 1853

8. AGE: Years 96 | Months 2 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Texas Md
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Owen Hanley
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine —
15. Birthplace Ireland

16 (a) Informant Owen F. Doyle
(b) Address 308 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 13-1948 (month) (day) (year)

(c) Cemetery or crematory St Joseph's Cem
Location Govans Md

18 (a) Funeral director Pratt & Strickert
(b) Address

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1948 at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1943 to Aug 11 1948 and that I last saw her alive on Aug 10 1948

Immediate cause of death Bronchopneumonia — Duration 1 day

Due to

Due to

Other Conditions generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan Roenon

Address 206 S. Gilmor St. Date signed 8.11.48

VS 190

G65800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 75a

Registered No. G65800

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balty (If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 N. Howard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriet Evelyn (EVELYN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Joseph

6 (c) If living, give age 73 years

7. Birth date of deceased (mo., day, yr.) 9-26-83

8. AGE: Years 64 Months 10 Days 14 If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name

13 Birthplace Va.

MOTHER 14. Maiden Name Alice Berman

15 Birthplace Va.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E Preston St

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10-48 3:50P

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22-48 to 8-10-48, and that I last saw her alive on 8-10 1948.

Immediate cause of death Terminal bronchopneumonia — Duration Days

Due to Severe Cachexia — minutes

Due to Splenic anemia with hepatomegaly and splenomegaly — years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Anemia, hepatomegaly, splenomegaly.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(c) Means of injury

23. Signature Courtney J. Page M. D.

Address JOHNS HOPKINS HOSPITAL Date signed 8-12-48

VS 150

65801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 65801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Hargrove St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Mack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: hr. min.
58 6 MT

9. Birthplace Montpelier S.C
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace SC

MOTHER
14. Maiden Name Unknown
15. Birthplace SC

16 (a) Informant Mrs Florena Berry
(b) Address 2101 Hargrove St

17 (a) Burial (b) Date thereof 8-14-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Bells National
Location

18 (a) Funeral director Rayner Sanders
(b) Address 412 E Preston St

19 (a) AUG 12 1948 (b) Huntington Williams, Md
(Date rec'd by registrar) (Address)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1948, at 9:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertrophy & dilatation of the heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl Rayner MED.
Medical Examiner.
Date signed 8-10-48

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 665802

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10A
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard PORTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Solman Porter

13. Birthplace Va

MOTHER 14. Maiden Name Lou ?

15. Birthplace Va

16 (a) Informant Mr Tilda Porter

(b) Address 1211 N Durham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-48 (month) (day)

(c) Cemetery or crematory Mt Calvary Balto

Location A. A. Co

18 (a) Funeral director Rayner Sanders

(b) Address 1117 E Preston St

19 AUG 12 1948 (a) (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1948, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to Malnutrition.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thos. A. Merrill M.D.
Medical Examiner.

Date signed 8/9/48

VS 151

665803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. 665803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 McElderry St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME (Erwin) Ervey Clary

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) .....

8. AGE: Years	Months	Days	If less than one day
40			hr. ..... min.

9. Birthplace Brunswick Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business .....

FATHER
12. Name John Clary
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth Tucker
15. Birthplace Va

16 (a) Informant Louis Clary
(b) Address Brunswick Va

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 8-12-48 (month) (day) (year)
(c) Cemetery or crematory Lawrenceville
Location Virginia

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) AUG 10 1948 (Date received by Registrar) Funeral for Williams, Mo Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1948, at 7½ P M

21. I certify that I took charge of the remains described above, held an Partial Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured skull & intracranial hemorrhage

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-30-48 at 9:45 P M.
(b) Where did injury occur? Front of 1105 McElderry St.
(c) Did injury occur at home, on farm, industrial place, or public place? public While at work? no
(d) Means of injury Struck by fist

23. Signature ..... M.D. Medical Examiner
Date signed 8-7-48

VIE 231

G665804

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G665804 Registered No. 122B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3704 Woodwald Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) FULL NAME ELLA MAGILL [Henry]

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thomas MAGILL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 Months Days If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edw. J. Lanahan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Manlove
15. Birthplace Ireland.

16 (a) Informant Mrs. Thomas Magill
(b) Address 3704 Woodwald Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St.

19 (a) Aug 12 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1948 at 8:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1948 to Aug 11 1948, and that I last saw her alive on Aug 11 1948.

Immediate cause of death Pulmonary Embolism — Duration

Due to Pneumonia

Due to Intestinal Obstruction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence (M)
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. L. Rehberger M. D.
Address St. Joseph's Hosp. Date signed 8-11-48

VS 150

65805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G65805

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rebecca & Green Street
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Frederick (If outside city or town limits, write RURAL and give town)
(d) Street No. 276 W. 5th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Harry C. James

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	Widower

6 (b) Name of husband or wife ~~Ella Pealey Sample~~

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 1 1866

8. AGE: Years	Months	Days	If less than one day
81	9	7	hr. min.

9. Birthplace Frederick, Frederick, Md. (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name William C. James
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Albaugh
15. Birthplace Md.

16 (a) Informant Mr. Harry T. James
(b) Address Frederick, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director M. R. Etchison & Son
(b) Address Frederick, Md.

19 AUG 12 1948 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1948 at 12:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1948 to August 11 1948. and that I last saw him alive on Aug. 11, 1948

Immediate cause of death	Duration
Respiratory & cardiac failure	
Due to Coronary thrombosis	25 min.
Due to Arteriosclerotic C.V. disease	Years
Other Conditions B.P.H. (Benign prostatic hypertrophy) (Include pregnancy within 3 months of death)	

Date of operation 8/4/48

Major findings of operation: Enlarged fibrous prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature J. J. Mennelan Jr. M.D.
Address University Hospital Baltimore, Md. Date signed 8/11/48

665806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. 665806

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123
(c) Hospital or institution South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) Diff
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 915 Leadenhall (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence (Fairstory) Van Story

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Widowed.

6 (b) Name of husband or wife Charles Cornish

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Unknown —

13. Birthplace

14. Maiden Name Florence Cornish

15. Birthplace Balto. Md.

16 (a) Informant Charles Vanstory

(b) Address 915 Leadenhall St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 8 14 48 (month, day, year)

(c) Cemetery or crematory Mt. Coley

Location Balto.

18 (a) Funeral director Walter B. Fry

(b) Address 1300 Hillendale Rd.

19 AUG 12 1948 (b) Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/48, 19 . at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Chronic Congestive Heart Failure

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Davis M.D.
Medical Examiner
Date signed 8/10/48

VS 151

65807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 65807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.H.
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Woodson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	WIDOWER

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day: hr.	min.
52				

9. Birthplace LUMBERG Co. VA. (Town, county, and state)

10. Usual Occupation LABORER.

11. Industry or business

FATHER
12. Name WM. WOODSON,
13. Birthplace VA.

MOTHER
14. Maiden Name LUCY GEE
15. Birthplace VA.

16 (a) Informant LUCY HAWTHORNE
(b) Address 928 Payson St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8 14 48 (month) (day) (year)
(c) Cemetery or crematory 8 14 48
Location MT. AUBURN

18 (a) Funeral director A. HALSTEAD
(b) Address 614 DRUID HILL AVE.

19 (a) AUG 12 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11 1948 at 9:00 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following.
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Fahnestock M.D. Medical Examiner.

Date signed 8/11/48

VS 151

65808

ES121374

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G65808

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Winston

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Helen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1879

8. AGE: Years	Months	Days	If less than one day
68?	10	4	hr. min.

9. Birthplace ? Balto. Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Patrick Winston
13. Birthplace ? Md.

MOTHER
14. Maiden Name ? Eliza Hall
15. Birthplace ? Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12 48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Robert Lee S. Williams
(b) Address 322 E. Lanvale St.

19 (a) AUG 12 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death Subarachnoid Hemorrhage — Duration 1 week
Due to
Due to
Other Conditions Bronchopneumonia — 1 week
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Subarachnoid Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Beckstold
Address Balto. City Hosp. Date signed 8/10/48

VS 150

G65809

RICKS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G65809

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 916 Rutland Ave.
(c) Hospital or institution: 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 Rutland ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward T. Ricks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Widower

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1876

8. AGE: Years	Months	Days	If less than one day
72	6	4	hr. min.

9. Birthplace N. Carolina (Town, county, and state)
10. Usual Occupation Laborer (Retired)
11. Industry or business steel

FATHER
12. Name Elijah Ricks
13. Birthplace N.C.

MOTHER
14. Maiden Name Martha Mitchell
15 Birthplace N.C.

16 (a) Informant Maggie Wilson
(b) Address 916 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12 1948 (month) (day) (year)
(c) Cemetery or crematory Gibutus Memorial Pk.
Location Gibutus Md.

18 (a) Funeral director Mrs. Robt. G. Elliott & Daughter
(b) Address 1125 N. Carolina St.

AUG 12 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9th 1948, at 6 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4 1948 to 8-9 1948 and that I last saw him alive on 8-8 1948

Immediate cause of death CARCINOMA of PANCREAS — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature RAYNER BROWNE, M.D. Date signed 8-11-48
Address 1500 EAST MADISON ST. BALTIMORE 5, MD.

vs

G65810

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G65810

C65810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. C65810

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2035 W. Fayette St.
(c) Hospital or institution: Bon Secours Hosp 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 321 Wyman Park Drive. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Libbie V. McNamara

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband or wife John A. McNamara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 6, 1885

8. AGE: Years	Months	Days	If less than one day
62	10	6	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant John A. McNamara.
(b) Address 321 Wyman Park Drive.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location

18 (a) Funeral director Paul E. Lohmeyer Jr.
(b) Address 1115 N Charles St.

19 AUG 12 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11 1948; at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 1948 to 8-11 1948, and that I last saw h[illegible] alive on 8-11 1948.

Immediate cause of death	Duration
Post Operative Cardiac failure.	
Due to operation for Cholecystectomy and Exploration of common duct	
Due to	
Other Conditions Cardiac pathology prior to operation.	

(Include pregnancy within 3 months of death)

Date of operation 10 Aug. 48.

Major findings of operation: Cholecystitis & Cholelithiasis - Stone common duct.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J R Liberto M. D.

Address Bon Secours Hosp Date signed 8/11/48

VS 120

G65811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G65811

Please write clearly and legibly. Use ink or indelible pencil.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 W. Chase Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 W. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter H. Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Annie Richardson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 17, 1884

8. AGE: Years	Months	Days	If less than one day
64	2	24	hr. min.

9. Birthplace Connecticut (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace M

MOTHER
14. Maiden Name Unknown
15. Birthplace M

16 (a) Informant Mrs. Annie Richardson
(b) Address 214 W. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Aug 12 1948 (Date received by Registrar) (b) Registrar.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1948 at 5:50 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/9/48 19 to 8/10 1948, and that I last saw him alive on 8/9/48 19

Immediate cause of death: Hypertensive Cardio-Vascular Disease — Duration: 48 hrs.
Due to
Due to
Other Conditions
(include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Thornton Grant, M. D.
Address 601 N. [illegible] Date signed 8/10/48

VS 153

65812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G65812

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1039 Hollins St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1039 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank V. Falice

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jessie G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 1st 1891

8. AGE: Years 57 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Produce Dealer

11. Industry or business Self

FATHER
12. Name Samuel Falice
13. Birthplace Italy

MOTHER
14. Maiden Name Nina
15. Birthplace Italy

16 (a) Informant Mrs Jessie G. Falice
(b) Address 1039 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory New Catholic Cem
Location 4300 Old Frederick Rd

18. (a) Funeral director John J. Gorman & Son
(b) Address 901-03 Hollins St

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10th 1948, at 5-05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1947 to 10 Aug. 1948, and that I last saw him alive on Aug. 10 1948

Immediate cause of death General Carcinomatosis

Duration 1 Year

Due to Carcinoma of Liver

Due to

Other Conditions Skeletal Metastasis Tuberculosis of Spine

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(d) Means of injury

23. Signature Charles Edmund M.D.
Address 910 W. Lombard Date signed 11 Aug. 1948.

VS 159

G65813 Witter ✓ G65813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9-2)

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3707 Belle ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 Belle ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rosalie Witter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John H. Witter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/12/1859

8. AGE: Years 88 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Herzog Stutzman

13. Birthplace Germany

MOTHER 14. Maiden Name Monega Beck

15. Birthplace Germany

16 (a) Informant Mr Frank E. Witter

(b) Address 3707 Belle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location 600 Frederick Road

18 (a) Funeral director J. Olney Doyle

(b) Address 1318 Light St.

AUG 12 1948 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1948 to Aug 11 1948 and that I last saw h[illegible] alive on Aug 10 1948

Immediate cause of death — Chronic Endocarditis — Duration 1 yr

Due to Arteriosclerosis — 1 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify any of these)
(e) Means of injury

23. Signature C. J. Whelan M.D.

Address 1279 Hilburn Ave Date signed 8/14/48

C65814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C65814 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted] Howard St
(c) Hospital or institution: Maryland General 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 61 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 N. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: LENA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1881

8. AGE: Years: 67 | Months | Days | If less than one day: hr. min.

9. Birthplace: RUSSIA (Town, county, and state)

10. Usual Occupation: RETIRED POLICEMAN

11. Industry or business

FATHER
12. Name: MAX MILLER
13. Birthplace: RUSSIA

MOTHER
14. Maiden Name: FANNIE
15. Birthplace: RUSSIA

16 (a) Informant: WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-12-48 (month) (day) (year)
(c) Cemetery or crematory: AITZ CHAIM
Location: WASH. BLVD

18 (a) Funeral director: JACK LEWIS INC
(b) Address: 2100 Eutaw Pl. Baltimore, Md.

19 (a) [illegible] by registrar [illegible]

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11/48 19 , at 445 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 19 to 8/11 1948, and that I last saw h alive on 8/10/48 19 .

Immediate cause of death: Coronary Occl. Sclerosis
Myocardial infarction

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: ? 4 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Myron B. Kush

Address 2320 Eutaw Place Date signed 8/11/48 M.D.

X

G65815

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G65815
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 N. Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 43 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 N. Collington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Levin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lena
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) — 1884
8. AGE: Years 64 Months Days If less than one day hr. min.
9. Birthplace ~~Russia~~ Russia (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Meyer
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Lena Levin
(b) Address 212 No Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-48 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Loudenslager Ave

18 (a) Funeral director Jack Lewyn Inc
(b) Address 2106 Eutaw Place

(a) (b)
Date received by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1948 at 5A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12, 1948 to Aug 12 1948, and that I last saw h in alive on Aug 12 1948

Immediate cause of death: Coronary Thrombosis — Duration: ½ hour
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thurlow Cooper M. D.
Address 2209 Eutaw Place Date signed 8/17/48

VS 159

G65816

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G65816

CERTIFICATE OF DEATH 55E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New Mexico (b) County
(c) City or town Taos (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 343 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME
Frank Lawrence Smithwick

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Lyna Smithwick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1912

8. AGE: Years	Months	Days	If less than one day
35	8	14	hr. min.

9. Birthplace New York City, (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business

FATHER
12. Name Francis Smithwick
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McCabe
15 Birthplace Ireland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/48 (month) (day) (year)
(c) Cemetery or crematory Fair View Cem
Location Santa Fe-New Mexico

18 (a) Funeral director Wm Cook Jrs
(b) Address 1217 St Paul St

AUG 12 1948 (Date received by Registrar) (b) Transcribed from Mortuary Record

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1948, at 12:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1948 to Aug. 12 1948, and that I last saw him alive on Aug. 12 1948.

Immediate cause of death 1-Carcinomotosis, primary site undetermined — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or Twn) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J. F. VAN HEKEN M.D.
Address U S Marine Hospital Date signed 8-12-48

J. F. VAN HEKEN X

G65817

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 56 E

Registered No. G65817

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore #18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3806 W. Hamilton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora A. Crummett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 15 1866

8. AGE: Years	Months	Days	If less than one day
81	10	3527	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Stephen Reynolds
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth Lam
15. Birthplace Virginia

16 (a) Informant Selma B. Calender
(b) Address 3806 W. Hamilton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-48 (month) (day) (year)
(c) Cemetery or crematory Rhodesville
Location Rhodesville, Va.

18 (a) Funeral director Young Bros
(b) Address 500 E Pratt St.

AUG 12 1948
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1948, at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1948 to Aug 12 1948 and that I last saw h alive on Aug 11 1948

Immediate cause of death Shock — Duration 8 hrs.

Due to Hemorrhage following excision of large Carbuncle

Due to

Other Conditions Tumor in abdomen

(Include pregnancy within 3 months of death)

Date of operation 8-11-48

Major findings of operation: Carbuncle c Gangrene on back

of autopsy: denied permission

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. H. Grant M.D.
M. D.
Address Maryland Gen Hosp Date signed 8-12-48

VS 130

G65818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G65818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4806 Monaments Ave
(c) Hospital or institution:
Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 + 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Springfield ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: Margaret L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17 1875

8. AGE: Years 72 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name John Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Dearing
15. Birthplace Ireland

16 (a) Informant Margaret L. Murphy
(b) Address 714 Springfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Old Frederick Road

18 (a) Funeral director John Lichtenberger
(b) Address 3000 E Baltimore St

AUG 12 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1948 at 2 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to Hypostatic C.V.

Other Conditions Diabetes

(Include pregnancy within 3 months of death.)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Rogers M.D. Medical Examiner
Date signed Aug 11 1948

107

G65819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. G65819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17 → 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Myrtle Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie Milan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-20-84

8. AGE: Years 64 | Months 6 | Days 3 | If less than one day: hr. min. 20

9. Birthplace No. Carolina (Town, county, and state)

10. Usual Occupation none

11. Industry or business

MOTHER'S MAIDEN NAME

12. Name Paul Lloyd

13. Birthplace No. Carolina

14. Maiden Name Melissa Strickland

15. Birthplace No Carolina

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 11-1948 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Brooklyn, Md

18 (a) Funeral director Elroy A. Wilson

(b) Address 1000 Blanchard Ave for Williams, Inc

19 (a) AUG 12 1948 (b) Registrar

MEDICAL CERTIFICATION

55 A

20. DATE OF DEATH August 10 1948 at 8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9 1948 to 8/10 1948. and that I last saw h alive on 8/10 1948.

Immediate cause of death Uremia — Duration: Aug 1947

Due to Carcinoma of Ant. Abd. and C. widespread — 1948

Due to metastases

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John Watt, Jr. M. D.

Address JOHNS HOPKINS HOSPITAL Date signed

VS 150

G65820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 330

Registered No. G65820

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Brooklyn Park (If outside city or town limits, write RURAL and give town)
(d) Street No. Joppa Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Rider

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Anna Rider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1887

8. AGE: Years	Months	Days	If less than one day
61	4	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Edward Rider
13. Birthplace Maryland

MOTHER
14. Maiden Name Ambia Ball
15. Birthplace Maryland

16 (a) Informant Anna Rider
(b) Address Joppa Rd - Brooklyn Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto.

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd.

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/9 1948 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1948 to 8/9 1948 and that I last saw h[illegible] alive on 8/9 1948

Immediate cause of death: Cardiac failure — Duration: 3-4 months

Due to Lung abscess

Due to Pneumonia over

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Henry V. Chase, M.D.
Address Mercy Hospital Date signed 8/9/48

VS 150

665821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 665821

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6004 Bertram
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6004 Bertram (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence E. Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Elizabeth C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30 (1880)

8. AGE: Years	Months	Days	If less than one day
67 (68)	4	13	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Crown, Cork & Seal

FATHER
12. Name George H. Green
13. Birthplace

MOTHER
14. Maiden Name Theresa Duffey
15. Birthplace

16 (a) Informant Mrs. Elizabeth Green
(b) Address 6004 Bertram Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Balto

18 (a) Funeral director L. J. Leuck
(b) Address 5305 Harford Rd

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Aug. 1948, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D.
Medical Examiner.
Date signed 12 Aug. 1948

VH 121

G65822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G65822

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 43, Route 13
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Gagen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/10/48

8. AGE: Years	Months	Days	If less than one day
			11 hr. 7 min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Russell D. Gagen
13. Birthplace Ohio

MOTHER
14. Maiden Name Elizabeth Lee
15. Birthplace Md

16 (a) Informant Father
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 (a) AUG 12 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10 1948, at 9:37 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10/ 1948 to 8/10 1948, and that I last saw her alive on 8/10 1948.

	Duration
Immediate cause of death Respiratory Failure	10 min
Due to Atelectasis	11 hrs
Due to Prematurity	6 months
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas D. Burgstaller M D
Address Mercy Hospital Date signed 8/12/48

VS 159

665823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 66B

Registered No. 665823

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 9-7
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Alameda Blvd #18 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen M. Farrell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced 5

6 (b) Name of husband or wife —

6 (c) If alive, give age / years

7. Birth date of deceased (mo., day, yr.) 5/23/04

8. AGE: Years 44 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Rhode Island (Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business

FATHER 12. Name Wm. James Farrell
13. Birthplace Rhode Is.

MOTHER 14. Maiden Name Helen F. Fitzpatrick
15. Birthplace Md.

16 (a) Informant Mr. Thomas Farrell
(b) Address 2904 Alameda Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director L. Luck
(b) Address 5 Harford Rd.

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11 1948 at 9 20 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/7 1948 to 8/11 1948, and that I last saw h alive on 8/11 1948.

Immediate cause of death: Cardiac failure — Duration
Due to: Hypertension
Due to:
Other Conditions: Chronically marked

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis J. Bayer M.D.
Address Maryland Gen. Hosp. Date signed 8/12/48

VS 159

102

65824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a ✓

Registered No. G65824

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2456 McCulloh St.
(If no street give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Johnston

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: M
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elizabeth C. Johnston
6 (c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Feb. 6 1876

8. AGE: Years 72 | Months 6 | Days 25 | If less than one day: hr. min.

9. Birthplace: Harrisville, Md.
(Town, county, and state)

10. Usual Occupation: Teacher

11. Industry or business

FATHER
12. Name: William Johnson
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden Name: Susan Cook
15. Birthplace: Balto. Co. Md.

16 (a) Informant: Mrs. Elizabeth C. Johnston
(b) Address: 2456 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location: Balto., Md.

18 (a) Funeral director: Wm. J. Chatman Jr.
(b) Address: 721 McCulloh St.

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1948 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-25-48 to 8-11 1948 and that I last saw h[illegible] alive on 8-11 1948

Immediate cause of death: Acute Myelogenous Leukemia — Duration: 7

Due to:

Due to:

Other Conditions: Recently Anemia — Duration: 7.
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: None

of autopsy: Acute Myelogenous Leukemia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Bernard Harris M. D.
Address: 1202 N. Carey Date signed 8/10/48

VS 180

Bernard Harris

G65825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65825
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4114 La Salle ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4114 La Salle
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin E. Gemmill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence D. Gemmill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 20-1893

8. AGE: Years 55 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Elec. Maintenance Foreman

11. Industry or business Gov. Harm. Piata Reg. a-

FATHER
12. Name Robert K. Gemmill
13. Birthplace Md

MOTHER
14. Maiden Name Lottie Echo
15. Birthplace Md

16 (a) Informant Mrs. Florence D. Gemmill
(b) Address 4114 La Salle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Baltimore Co Md

18 (a) Funeral director Geo. H. Berger Jr
(b) Address 45 N Hollins Ave Baltimore, Md

19 (a) AUG 12 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1948, at 6.45A

21. I certify that death occurred on the date above stated; that I attended deceased from 29. 12. 1947. to 20. 6. 1948. and that I last saw him alive on 20. 6. 1948.

Immediate cause of death: Heart failure — Duration:

Due to Chronic bronchitis and emphysema with asthma, severe — 29 yrs.

Due to

Other Conditions Chronic glomerulo-nephritis — 2

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. D. Gemmill M. D.

Address 7122 Harford Rd Date signed 11 Aug 48

VS 150

106 C

G65826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G65826 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fairwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Lee Watts

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Nellie Mary Watts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 - 1870

8. AGE: Years	Months	Days	If less than one day
77	7	16	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Elevator operator (Ret)

11. Industry or business

FATHER
12. Name Oliver Watts
13. Birthplace Md

MOTHER
14. Maiden Name Sophie Weller
15. Birthplace Md

16 (a) Informant Mrs Nellie Mary Watts
(b) Address 714 Edmondson Ave Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md

18 (a) Funeral director Geo. L. Rayner Jr
(b) Address 1512 Hollins St Funeral Home Baltimore, Md

19 (a) AUG 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11 1948 at 0 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4-48 1948 to 8-11 1948 and that I last saw h/ alive on 8-11 1948

Immediate cause of death Respiratory failure

Due to Pulmonary Edema

Due to Arteriosclerotic C-V Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Veterans Hosp Date signed 8/14/48

VS 150

Ps1G65827

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G65827
Registered No.

CERTIFICATE OF DEATH 124 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Washington (b) County D C
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 5236 Nebraska ave (If rural give location)
(e) Citizen of foreign country? U. S. A. (Yes or No)
If yes, name country

3 (a) FULL NAME John Tavenner

3 (b) If veteran, name war: none | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 10-31-89

8. AGE: Years 58 | Months 9 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business

FATHER
12. Name Richard Tavenner
13. Birthplace Va

MOTHER
14. Maiden Name Molly Beals
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal)
(b) Date thereof 8-16-48 (month) (day) (year)
(c) Cemetery or crematory Glenwood Cemetery
Location Washington D.C.

18 (a) Funeral director J. Willis Sullivan & Sons Co.
(b) Address 3000 14th St Washington D.C.

AUG 12 1948
(Date rec'd by registrar)

(b) Embalmer [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12-1948, at 12:45 a. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23-1948 to 8-12-1948 and that I last saw him alive on 8-12-1948.

Immediate cause of death: Cholemia and Coma — Duration: 1 day

Due to: Cirrhosis of the Liver — Duration: 6 months

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Cirrhosis of Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify b[illegible])
(e) Means of injury
23. Signature Evan Calkins M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

X

G65828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G65828

CH. 120118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 653 W. Lombard ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. McHale

3 (b) If veteran, name war Methodist

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Div.

6 (b) Name of ~~husband or~~ wife Henrietta McHale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21 1883

8. AGE: Years 66 | Months 1 | Days 16 | If less than one day: hr. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation Freight Conductor

11. Industry or business

FATHER
12. Name Thomas McHale
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McHale
15. Birthplace Ireland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/13/48 (month) (day) (year)
(c) Cemetery or crematory St. Josephs
Location Staten Island N.Y.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

18 (c) AUG 13 1948 (Date received by registrar) Huntington Williams, Jr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8- 7 - 1948 at 10.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6- 1 -1948, to 8- 7- 1948 and that I last saw him alive on 8 - 7- 1948.

Immediate cause of death Myocardial Infarction — Duration 4 Days.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Beckbold, M.D.
Address Balt. City Hosp. Date signed 8/14/48

65829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 12B

Registered No. 65829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dot
(c) Hospital or institution: So. E. Balt General Hospital

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside limits, give township)
(d) Street No. 1013 Peach Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME Alberta Marston (Tubman)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Thomas Tubman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/15/1895

8. AGE: Years 52 | Months 10 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Ht Wk

11. Industry or business

FATHER
12. Name Harriet Marston
13. Birthplace Md

MOTHER
14. Maiden Name Lucy ?
15. Birthplace Md

16 (a) Informant Thomas Tubman
(b) Address 1013 Peach Alley

17 (a) Burial (b) Date thereof 8-14-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. Co. Md

18 (a) Funeral director Samuel E. Runnels
(b) Address 108 N Monteomery St

19 (a) AUG 13 1948 (b) Huntington for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8 1948, at 7 20 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tbc

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Fulmer M.D.
Medical Examiner.
Date signed 8/9/48

VS 151

G65830 SC-B-Gold

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G65830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible]
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 412 N. Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/7/48

8. AGE: Years	Months	Days	If less than one day
			7 hr. 10 min.

9. Birthplace Balt. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Johnson
13. Birthplace Akron Ohio

MOTHER
14. Maiden Name Mildred Pearson
15. Birthplace Littleton, N.C.

16 (a) Informant Mildred Johnson
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Bethel Cemetery
Location

18 (a) Funeral director [illegible] AUG 12 1948
(b) Address

19 (a) Date received by registrar (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8 1948, at 1:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6:20 PM 8-7 1948, to 8-8 1948, and that I last saw h[illegible] alive on 8-8 1948.

Immediate cause of death Respiratory failure — Duration

Due to Subnormal vitality

Due to Prematurity 33 weeks

Other Conditions Chronic Pyelonephritis, Congenital Heart Disease, Congenital Anomalies of Kidneys, Congenital Cleft Palate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Gold M. D.
Address Univ. Hosp. Date signed 8-8-48

VS 190

[illegible] Williams, M.D.

665831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. 665831

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 18 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town 38 Kingston Pk. Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 38 Kingston Park
(If rural give location)
(e) Citizen of foreign country? N.D. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Truce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/10/48

8. AGE: Years | Months | Days | If less than one day 18 hr. s. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER
12. Name Garman Truce
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Knight
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School AUG 12 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) AUG (Date rec'd) 1948 Registrar Brighton Williams, M.D. Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1948, at 11.11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1948, to Aug. 10 1948, and that I last saw him alive on Aug. 10 1948.

Immediate cause of death: Intracranial hemorrhage — Duration: 18 hrs

Due to: Birth Injury

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: fracture, skull; Cerebral Contusion

of autopsy: Atelectasis, Left Lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Dorman Jr.

Address 3101 St. Paul St. Date signed Aug. 10, 1948 M D

065832 48-14561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. 065832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Univ. Hosp. 11-39
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town) MADISON AVE
(d) Street No. 1711 Madison Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-30-48

8. AGE: Years	Months	Days	If less than one day
	1	3 9 1	hr. min.

9. Birthplace Univ. Hosp. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Brother Roberts
13. Birthplace Roan Co. N. Carolina

MOTHER
14. Maiden Name Hattie STATON
15. Birthplace Salton, N. Carolina

16 (c) Informant Mother
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery [illegible] AUG 12 1948
Location

18 (a) Funeral director [illegible]
(b) Address

19 (a) Date AUG 12 1948 (b) [illegible]
(Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8-48 19 , at 10 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948 to 8-8 1948, and that I last saw him alive on 8-8 1948.

Immediate cause of death Atelectasis Aspiration of Lung, Congenital Emphysema (Primary)

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. J. Lambrou Jr. M. D.

Address Univ. Hosp. Date signed 8-8-48

VS 150

65833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 65833

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2821 Hilldale Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2821 Hilldale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Meyer M. Hornstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ada Nee Levy
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec, 12, 1890

8. AGE: Years	Months	Days	If less than one day
57	8	-	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business Salesman

FATHER
12. Name Kalman Hornstein
13. Birthplace Poland

MOTHER
14. Maiden Name Carrie Meyers
15. Birthplace Poland

16 (a) Informant Ada Hornstein
(b) Address 2821 Hilldale Ave

17 (a) Burial (b) Date thereof Aug 13, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (Date received by Registrar) AUG 13 1948 (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1948, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25 1948 to 8/12 1948, and that I last saw him alive on 8/12 1948.

Immediate cause of death: Carcinoma of Stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/18/48

Major findings of operation: Carcinomatosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 73 Rd Eutaw St Date signed 8/14/48

VS 15)

65834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G65834

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Wilkens ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME J. Stuart Bond

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Clara Emaugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James Bond
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth Lyon
15. Birthplace Baltimore Md

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 13 48 (month) (day) (year)
(c) Cemetery or crematory Dixie Memorial
Location Baltimore Md.

18 (a) Funeral director C. B. Heath and Son
(b) Address 502 N. Calvert St.

19 (a) AUG 13 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1948 at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11/48 to 8/11/48 and that I last saw him alive on 8/10/48.

Immediate cause of death	Duration
CARDIAC FAILURE	
MYOCARDIAL INFARCTION	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W. Wilson M.D.
Address 502 N. Eutaw St. Date signed 8/14/48

VS 189

X

665835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. 665835

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 72 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 121 W. Susquehanna Avenue
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Anna Donahue

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fe.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Martin Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1904

8. AGE: Years 44 | Months 3 | Days 17 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Wife.

11. Industry or business

FATHER 12. Name: Michael Stelta

13. Birthplace: Germany

MOTHER 14. Maiden Name: Hedwig Hedener

15. Birthplace: Austria

16 (a) Informant: Mrs Francis Smith

(b) Address: Montgomery Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/48 (month) (day) (year)

(c) Cemetery or crematory: St. Johns

Location: Govans, Md

18 (a) Funeral director: Leonard J. Buck

(b) Address: 530 E. Hoffman St.

AUG 13 1948 (Date rec'd by registrar)

(b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 1948, at 8:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1/ 1948 to 8/12/ 1948 and that I last saw her alive on 8/12/48 19

Immediate cause of death: Respiratory failure

Due to: Cachexia

Due to: Carcinomatosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: December, 1947

Major findings of operation: Carcinoma of uterus.

of autopsy: Carcinomatosis.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Anthony F. DiPaula M. D.

Address: St. Joseph's Hosp Date signed 8/12/48

VS 186

X

665836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. 665836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Rural (Sykesville)
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Walter Gamber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	w. divorced

6 (b) Name of husband or wife: Bertha Bercaft
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Finksburg Carroll Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George W Gamber
13. Birthplace Maryland

MOTHER
14. Maiden Name Christy ann Galston
15. Birthplace Maryland

16 (a) Informant Mrs Chas Carr
(b) Address 6500 Belmont Ave Baltimore #2nd floor

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14, 48 (month) (day) (year)

(c) Cemetery or crematory Calvary
Location Gamber Carroll Co. md

18 (a) Funeral director Wm B Grey Mangum Inc
(b) Address Reisterstown, Md

19 (a) AUG 13 1948 (Date rec'd by registrar) (b) [illegible] Washington, D.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1948 at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1948 to Aug 11 1948 and that I last saw h[illegible] alive on Aug 11 19 48.

Immediate cause of death	Duration
Coronary thrombosis hypostatic pneumonia	
Due to Senile pneumonic changes Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Aug 4, 1948
Major findings of operation: Biopsy prostate of small tumor ganglioneuroma.
of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Martin M.D. M. D.
Address Maryland General Hosp. Date signed 8-11-48

VS 193

G65837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 948

G65837
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert
(c) Hospital or institution: Union Memorial Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 No. Lemwood Ave. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Baccerics

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Jeanette

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1884

8. AGE: Years	Months	Days	If less than one day
64	1	27	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Shoe Repairman

11. Industry or business

FATHER
12. Name
13. Birthplace Poland

MOTHER
14. Maiden Name
15 Birthplace Poland

16 (a) Informant Mrs. Agnes Pugsley
(b) Address 228 N. Lemwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 14 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Cross National Catholic
Location Gilman Hill Road Balto. County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) AUG 13 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 - 10 1948 at 11: AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 - 10 1948 8 - 10 1948 and that I last saw h alive on 8 - 10 1948

Immediate cause of death	Duration
Coronary sclerosis	
Due to Coronary artery disease	
Due to	
Other Conditions Pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Charles Craighead M. D.
Address Union Memorial Hospital Date signed 8/10/48

VS 153

65838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G65838

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d. & Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 Dunkirk Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lieut. John Henry Kratz

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed or divorced Widowed

6 (b) Name of husband Anna Margaret Kratz | 6 (c) If alive, give age 3 years

7. Birth date of deceased (mo., day, yr) Nov. 13, 1861

8. AGE: Years 86 | Months 9 & 29 | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None (Retired)

11. Industry or business Lieut. Police Dept

FATHER 12. Name Walter A. Kratz

13. Birthplace Germany

MOTHER 14. Maiden Name Anna Cook

15. Birthplace Germany

16 (a) Informant Mrs. Louise Manninger

(b) Address 311 Dunkirk Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14/48 (month) (day) (year)

(c) Cemetery or crematory Carlwood Mem. Park

Location Relay

18 (a) Funeral director Philip Henry Sons

(b) Address 2024 Eutaw Pl

19 (a) Date received AUG 13 1948 (b) Registrar Transcribed for Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 – 12 1948, at 12 noon

21. I certify that death occurred on the date above stated; that I attended deceased from 8 – 9 1948 to 8 – 12 1948 and that I last saw him alive on 8 – 12 1948

Immediate cause of death Uremia — Duration

Due to Benign prostatic hypertrophy. Catheterization

Due to Arteriosclerosis & Senescence.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H. Dawson, M. D.

Address Date signed

VS 130

X

G65839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G65839

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3019 Fendall Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 Fendall Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel DeLuca

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Adolph DeLuca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 4, 1891

8. AGE: Years	Months	Days	If less than one day
57	6	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Benj. Allen,
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Amelia Baumann
15. Birthplace Balto Md.

16 (a) Informant Mr. August DeLuca
(b) Address 3019 Fendall Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. Willis Lamoreau
(b) Address 4510 Liberty Heights Ave.

19 (a) AUG 13 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1948 at 12.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1948 to Aug. 8 1948 and that I last saw h[illegible] alive on Aug 8, 1948.

Immediate cause of death Cerebral hemorrhage — Duration, 10 min.

Due to

Due to

Other Conditions Diabetes mellitus — 30 yrs.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. E. Harper M. D.
Address 5201 Perry Dale Ave Date signed Aug 11, 48

VS 150

83a

65840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G65840 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & SARATOGA
(c) Hospital or institution: Mercy Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALT.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 6325 Hudson (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME James Poe Jr. (JAMES EMERY POE, JR.)

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7/11/46

8. AGE: Years 2 | Months 1 | Days | If less than one day hr. min.

9. Birthplace MORGAN TOWNS, W.Va. (Town, county, and state)

10. Usual Occupation NONE.

11. Industry or business

FATHER
12. Name James Poe
13. Birthplace GRAFTON, W.Va.

MOTHER
14. Maiden Name Helen SEMANICK
15. Birthplace GRAFTON, W.Va

16 (a) Informant Mr. James E. Poe - father
(b) Address 6325 Hudson Street -24

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE & BROADWAY

19 (a) AUG 13 1948 (Date rec'd by local registrar) Secretary for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11/48 1948 at 11:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1948 to 8/11 1948
and that I last saw him alive on 8/11/48 19

Immediate cause of death	Duration
Acute Resp. Failure	
Due to Acute Lymph. Leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Aponte, M.D.
Address Emergency Date signed 8/11/48

6655842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 665841

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 39 S. Highland Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 39 S. Highland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD FRANKLIN JENKINS

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212-01-9831

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alice Lawton Jenkins

6 (c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Oct. 13, 1872

8. AGE: Years: 75 | Months: 9 | Days: 29 | If less than one day: hr. min.

9. Birthplace: A.A. County, Md.
(Town, county, and state)

10. Usual Occupation: Engineer -1st. Grade

11. Industry or business: Sanitary Corp.

FATHER
12. Name: Wm. Jenkins
13. Birthplace: Maryland

MOTHER
14. Maiden Name: ? King
15. Birthplace: Maryland

16 (a) Informant: Mrs. Alice Lawton Jenkins
(b) Address: 39 S. Highland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/14/48 (month) (day) (year)
(c) Cemetery or crematory: Magothy Church cemetery
Location: A.A. County, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (b)
(City or town) (State)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11, 48, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 2 19 48 to Aug 10 19 48 and that I last saw h[illegible] alive on Aug 10 19 48

Immediate cause of death: Coronary Embolism

Due to: Arteriosclerosis

Due to: Hypertension

Other Conditions:
(Include pregnancy within 3 months of death)

Duration: 6 weeks

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: M. A. Jacobs, M. D.
Address: 617 North St. Date signed: 8/11/48

Filed [illegible] 1948 Registrar

VS 180

G65842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G65842 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 William St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ADDIE MAY GISRIEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Edward C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV 4 1884 Inquired

8. AGE: Years	Months	Days	If less than one day
63	9	8	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Joseph Simmons
13. Birthplace Md

MOTHER
14. Maiden Name Rhoda Tyson
15. Birthplace Md

16 (a) Informant Mr. Edward Gisriel
(b) Address 828 William St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14/48 (month) (day) (year)
(c) Cemetery or crematory Hopewell
Location Bot Deposit Md

18 (a) Funeral director Harry H Witzke
(b) Address 1101 Edmondson Ave

AUG 13 1948 (Date filed) (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1948 at 11 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 5 1948 to August 12 1948, and that I last saw her alive on August 12 1948.

Duration
Immediate cause of death Strangulated Hernia (Obstruction)
Intestinal Perforated & Generalized Peritonitis
Due to
Due to
Other Conditions Auricular Fibrillation & Marked Decompensation.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Inguinal

of autopsy Strangulated Femoral Hernia

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allan E. Gerardi M. D.
Address 1213 Light St. Date signed 8-12-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

G65843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 12 B

Registered No. G65843

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 Bank Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Bank Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK T. DROZD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Josephine
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) October 9, 1894

8. AGE: Years	Months	Days	If less than one day
53	10	3	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name Michael Drozd
13. Birthplace Poland

MOTHER
14. Maiden Name Rozalia Bogdan
15. Birthplace Poland

16 (a) Informant Mr. Joseph Drozd
(b) Address 305 S. Ann Street

17 (a) Burial (b) Date thereof 8/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Avenue

AUG 13 1948 Huntington Williamson
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Aug. 1948 at 2.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 July 1948 to 10 Aug 1948 and that I last saw him alive on 10 Aug 1948

Important cause of death	Duration
Respiratory failure	
Due to Pneumonia	2 da.
Due to	
Other Conditions Pulmonary Tbc. Intermittent hemoptysis.	yrs. ?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Drozd
Address 2601 Eastern Ave Date signed M. 8 D. 13/48

VS 150

109 C1

665844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G65844

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mo. and 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 S. Albemarle Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Salvatore Pisano

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	widower

6 (b) Name of husband or wife late Adelina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1897

8. AGE: Years	Months	Days	If less than one day: hr.	min.
50	11	1		

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Seafarer

11. Industry or business

FATHER
12. Name Giuseppe Pisano
13. Birthplace Italy

MOTHER
14. Maiden Name Filippa Lanza
15. Birthplace Italy

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14 1948 (month) (day) (year)
(c) Cemetery Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Vecchia
(b) Address 322 S. High St.

19 (a) AUG 13 1948 (Date rec'd by registrar) [signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1948, at 2:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 27 1947, to August 12 1948 and that I last saw him alive on Aug. 12 1948.

Immediate cause of death	Duration
Carcinoma of the bronchus with metastases to regional nodes and brain	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address Marine Hospital, Balto. Md. Date signed 8-12-48
J. F. van Aokeren

VS 190

G65845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. G665845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 N. Schroeder
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 N. Schroeder St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John E. Spence.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sarah Spence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1885

8. AGE: Years 63 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Snowhill, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Spence.
13. Birthplace Snowhill, Md.

MOTHER 14. Maiden Name Mary
15 Birthplace Snowhill, Md.

16 (a) Informant Sarah Spence.
(b) Address 401 N. Schroeder St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Tate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) [illegible] 13 [illegible] (Date rec'd by registrar) (b) Pennington for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1948 at 12:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-10-47 19..., to 8-12, 1948.
and that I last saw him alive on 8-11-1948.

Immediate cause of death: Congestive Heart Failure — Duration: 3 wks.
Due to Hypertension — 3700
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. McDaniel M. D.
Address 807 N. Caroline Date signed 8-13-48

VR 100

65846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. 65846

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 Diamond St.
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 Diamond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Hart.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Femal
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daniel Hart.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 1, 1906

8. AGE: Years: 42 | Months: 2 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Scranton, Penna. (Town, county, and state)
10. Usual Occupation: Housewife.
11. Industry or business

FATHER
12. Name: William Smith.
13. Birthplace: Virginia.

MOTHER
14. Maiden Name: Emma -
15. Birthplace: Penna.

16 (a) Informant: Daniel Hart.
(b) Address: 322 Diamond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 13 1948 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location

18 (a) Funeral director: Mrs. Katie R. Williams
(b) Address: 322 N. Schroeder St.

19 (a) AUG 13 1948 (Date rec'd by registrar)

Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/10 1948, 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2 1948 to 8/10 1948, and that I last saw h[illegible] alive on 8/10 1948.

Immediate cause of death: Bronchopneumonia
Due to: Cardiovascular disease
Due to:
Other Conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)

Duration: 6 Months

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: William M. Garner M.D.
Address: 753 Georges St. Date signed: 8/12/48

X

65847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G65847 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 S. Patterson Park Ave
(c) Hospital or institution:
St. Joseph's Home For The Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 S. Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Napora

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband~~ or wife Maryanna

6 (c) If alive, give address ~~Deceased~~

7. Birth date of deceased (mo., day, yr.) Unknown ?

8. AGE: Years	Months	Days	If less than one day
? 80 About			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Jozef Napora
13. Birthplace Poland

MOTHER
14. Maiden Name Zofia Barnas
15. Birthplace Poland

16 (a) Informant Rose Budny (Daughter)
(b) Address 6913 Holabird Ave (Dundalk)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-48 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director Rose A Weber
(b) Address 705 South Ann Street

19 (a) AUG 13 1948 (Date received by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12th 1948, at 12 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 1948 to Aug. 12 1948, and that I last saw him alive on Aug. 12 1948

Immediate cause of death	Duration
ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE	???
Due to	
Due to	
Other Conditions CHRONIC BRONCHITIS WITH ASTHMA (include pregnancy within 3 months of death)	1/7/45

Date of operation NONE

Major findings of operation:

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Dragon M. D.
Address 209 N. Chester St Date signed 8/12/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65848

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelius O. Bagent

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Nannie Bagent
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1885

8. AGE: Years 63 | Months 2 | Days 1 | If less than one day: hr. min.

9. Birthplace Hagerstown, Maryland
(Town, county, and state)

10. Usual Occupation Confectioner
11. Industry or business

FATHER
12. Name Jacob Bagent
13. Birthplace Unknown

MOTHER
14. Maiden Name Anna Andrews
15. Birthplace Unknown

16 (a) Informant Mrs. Nannie Bagent
(b) Address 1836 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A. Co. Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pennsylvania Aves.

19 (Date rec'd by registrar) AUG 13 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12-48 1948, at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-22 1948 to 8-12-48 1948, and that I last saw him alive on 8-12 1948.

Immediate cause of death: Uremia — Duration

Due to Hypertensive Cardio-Vascular Arteriosclerotic Heart Disease

Due to

Other Conditions Prostatic Hypertrophy

(Include pregnancy within 3 months of death)

Date of operation 7-3-48

Major findings of operation: Prostatic Hypertrophy

of autopsy: Arteriosclerosis, generalized

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. W. Bindeman M.D.
M. D.
Address W. B. & G. N. Date signed 8-14-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G65849

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 83a

G65849
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 E. Tunbridge Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 E. Tunbridge Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H. CHAPMAN

3 (b) If veteran, name war: None

3 (c) Social Security Account No.? /

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Susie R. Chapman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1860

8. AGE: Years 88 | Months 0 | Days 26 | If less than one day: hr. min.

9. Birthplace Talbot Co. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Peter Chapman
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Susie R. Chapman
(b) Address 507 Tunbridge Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Spring Hill
Location Easton, Md.

18 (a) Funeral director W.M. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17

19 (a) AUG 13 1948 (b) [illegible] Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11, 1948 10 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1948 to Aug. 11 1948.
and that I last saw him alive on Aug 11 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carl H. Benson, M.D.
M. D.
Address 5111 York Rd Date Aug 13, 1948

VS 150

G65850 G65850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. ____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 129 N. Milton Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ____
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 129 N. Milton Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country ____

3 (a) FULL NAME MARY MARGARET JENNINGS

3 (b) If veteran, name war ____ | 3 (c) Social Security Account No. ____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Andrew F. Jennings
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) Oct. 8, 1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
82	10	4		865

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Gephardt
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Trunk
15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. Hazel M. Smith - daughter
(b) Address 129 N. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Harford Ave., Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

(c) Signature of Registrar Secretary for Williams M.D. Registrar

AUG 17 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12th 1948 at 7:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17th 1948 to Aug 11th 1948 and that I last saw h alive on Aug 11th 1948

Immediate cause of death Cerebral Embolism — Duration 3 days

Due to Carcinoma — 2

Due to ____

Other Conditions ____
(Include pregnancy within 3 months of death)

Date of operation ____
Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury ____

23. Signature H J Taylor M. D.
Address 100 N. Mallory Date signed 8/13/48

VS 130

G65851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Schlag XV G65851 95c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Funeral Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) –

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore - Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt #15 Box 193 Beaver
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Schlag

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Ewald

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/8/84

8. AGE: Years 64 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Nicholas Birchukow

13. Birthplace Russia

14. Maiden Name Fienke

15. Birthplace Hamburg, Germany

16 (a) Informant Ewald Schlag - husband

(b) Address Route 15, Box 193, Balto-20-Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location 7225 Eastern Ave., Balto. Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.

(b) Address 2601-3-5 E. Madison Street

(a) Date received by registrar Huntington Woods (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1948 at 7 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/25 1948 to 8/11 1948, and that I last saw her alive on 8/10 1948.

Immediate cause of death: Cardiac failure — Duration

Due to: Cor pulmonale

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Charles Klapp M.D.

Address Maryland Square Date signed 8/11/48

G65852 BALTIMORE CITY HEALTH DEPARTMENT G65852

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1222 Holbrook St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 Holbrook St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Leo Callender
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Jessie M. Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1898

8. AGE: Years	Months	Days	If less than one day
49	10	16	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Iron Worker
11. Industry or business Consolidated Eng. Co.

MOTHER / FATHER
12. Name Wm. E. Callender
13. Birthplace Balto. Md.
14. Maiden Name Laura E. Martin
15. Birthplace Balto. Md.

16 (a) Informant Jessie M. Callender (wife)
(b) Address 1222 Holbrook St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

(a) 8-2-1948 (Date received by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12/48 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1948 to Aug 12 1948, and that I last saw h[illegible] alive on Aug 12 1948.

Immediate cause of death Pulmonary Tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Chas. Faul M. D.
Address Dr. Local Fusion Date signed

VS 150

Ost-G65853

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30C

✓ G65853 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1231 S. Matthew St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James L. Brandon

3 (b) If veteran, name war: C
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Sep

6 (b) Name of husband or wife: ?

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 6-27-98

8. AGE: Years 50 | Months 10 | Days 15 | If less than one day: hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER
12. Name James Brandon
13. Birthplace ?

MOTHER
14. Maiden Name Nancy Bubbel
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13-48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy B. Wilson
(b) Address 1107 Edmondson ave

19 (a) (Date received by Registrar) (b) Registrar
AUG 18 Washington Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 12 1948 19 at 12.05 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1948 to 8-12 1948 and that I last saw him alive on 8-12 1948.

Immediate cause of death Cerebro-Vascular accident — Duration 24hrs

Due to Syphilis-meningovascular Arteriosclerosis

Due to

Other Conditions Hypertensive Cardio Vascular disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard S Ross M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 12 Aug 48

X

G65854

BALTIMORE CITY HEALTH DEPARTMENT ✓ G65854

CERTIFICATE OF DEATH 46a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Church Home + Hospital
(c) Hospital or institution: Broadway + Fairmount Ave.
(d) Length of stay in hospital or inst. (~~give number of~~ days) 14 yr
(e) Length of stay in Baltimore (yrs., ~~months or days~~) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 S. Caroy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Backhaus, Mr. Albert

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 218-10-2576

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mrs Martha Backhaus
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug 14. 1879

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	11	28		

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Mgr. Restaurant
11. Industry or business Restaurant

FATHER
12. Name Backhaus, Mr. Friedrich
13. Birthplace Germany

MOTHER
14. Maiden Name Mrs. Weisenborn
15. Birthplace Germany

16 (a) Informant Mrs. Albert Backhaus
(b) Address 1421 S. Caroy St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16. 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Mr. + Mrs. Conn R. Teufelson
(b) Address 5311 Edmondson Ave.

19 (a) [illegible] (b) Huntington [illegible]
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1948 at 7 05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 1948 to 8-12 1948 and that I last saw h[illegible] alive on 8-12 1948.

Immediate cause of death Cardio-resp. failure. — Duration: 15 hrs.

Due to Atalectasis, left

Due to Atalectasis + postural pneumo thorax, L.

Other Conditions C.A. resection Ca esophagus

(Include pregnancy within 3 months of death)

Date of operation 8-10-48

Major findings of operation: Ca of esophagus

of autopsy: confirmed above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. Robert Haase M. D.
Address Church Home + Hosp. Date signed 8-12-48

VS 150

F. Robert Haase X

G658555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G658555 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da's
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2456 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H. LAWSON

3 (b) If veteran, name war **

3 (c) Social Security Account No. 219-20-9522

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jane R. Lawson

6 (c) If alive, give age: D. years

7. Birth date of deceased (mo., day, yr.): Jan. 13 1884

8. AGE: Years 64 | Months 6 | Days 29 | If less than one day ******** hr. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual Occupation: Merchant - Retired

11. Industry or business

FATHER
12. Name: George S. Lawson
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Susan Tyson Harvey
15. Birthplace: Maryland

16 (a) Informant: S. Howard Lawson (son)
(b) Address: 114 S. Kossuth Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 14/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore Maryland

18 (a) Funeral director: F.B. WIPPERT & SON
(b) Address: 1300 EUTAW PLACE..17

(c) Filed rec'd by registrar: Aug 14 1948 Thorlington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11th 1948, at 3:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8. 1948 to Aug. 11 1948 and that I last saw him alive on Aug. 11 1948.

Immediate cause of death: Cerebral Vascular Accident — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John H. Shaw M. D.

Address: St. Agnes Hosp. Date signed: 8/11/48

VS 150

DR. JOHN H. SHAW. M.D.

356

BALTIMORE CITY HEALTH DEPARTMENT ✓ 665856
Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 N.
(c) Hospital or institution: Balto City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Lennox St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Evatt "John J. Evatt Hy) Evatt"

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22 1880

8. AGE: Years	Months	Days	If less than one day
68	5	20	hr. min

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Pipe Fitter

11. Industry or business B. & O. R. R.

FATHER
12. Name George R. Evatt
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth McCarthy
15. Birthplace Baltimore Md

16 (a) Informant Mrs Virginia E. Rodgers
(b) Address 1910 W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director T. B. Hubbard & Son
(b) Address 1300 Eutaw Place
Huntington Williams

AUG 1948
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11 1948 at 11:27 A M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Fulwood M.D.
Medical Examiner.
Date signed 8/11/48

G65857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G65857 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st Sts.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 Yorkway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Edward Brown (Also, William A. Reese)

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1893

8. AGE: Years	Months	Days	If less than one day
54	10	16	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Seafarer
11. Industry or business

FATHER
12. Name John Brown (Reese)
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Josephine Simons
15. Birthplace Pennsylvania

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

AUG 13 1948 Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1948, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1948 to Aug. 12 1948, and that I last saw him alive on Aug 12 1948.

Immediate cause of death	Duration
1-Hypertensive cardiovascular disease with cardiac insufficiency	unknown
Due to	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy: As above	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

25. Signature [signature] M. D.
Address Marine Hospital, Baltimore, Md. Date signed 8-12-48

VS 199

G65858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127B

G65858 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mths
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5216 Cowsan Ave #12 CROWSON (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Sweeney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7/10/1860

8. AGE: Years	Months	Days	If less than one day
88	1	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Daniel Sweeney
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McGee
15. Birthplace Ireland

16 (a) Informant John M Buchanan M.D.
(b) Address Mercy Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month) (day) (year)
(c) Cemetery or crematory St. Mary's - Govans
Location City

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount & 22nd

AUG 13 1948 (Date received by registrar) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1948 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1948 to Aug 11 1948, and that I last saw him alive on Aug 11 1948.

Immediate cause of death: Heart failure
Due to Asthma
Due to Non-function of Kidneys Bronical Pneumonia
Other Conditions Probable ruptured bladder

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John M Buchanan M. D.
Address Mercy Hospital Date signed 8-11-48

VS 150

665859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1630

665859
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2916 Calvert Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest P. Weil

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife MARGUERITE B. WEIL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
44	—	—	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation SALESMAN-
11. Industry or business

FATHER
12. Name JOHN C. WEIL
13. Birthplace (?)

MOTHER
14. Maiden Name IRENE STRITHOFF
15. Birthplace Balto., Co.

16 (a) Informant MRS. MARGUERITE B. WEIL
(b) Address 2916 N. CALVERT ST. -

17 (a) BURIAL (b) Date thereof 8-14-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location CITY -

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT & 22ND -

19 AUG 13 1948 (Date received by Registrar) (Funeral Director) Huntingtown, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1948, at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Barbital Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-11-48 at P.M.
(b) Where did injury occur? 2916 Calvert St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home (While at work?) no
(d) Means of injury Ingestion of Barbital tablets

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 8-12-48

G65860 ✓ G65860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 W. Lanvale St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country none

3 (a) FULL NAME Elizabeth James McCoy

3 (b) If veteran, name war none

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/15/20

8. AGE: Years 28 | Months 7 | Days 26 | If less than one day — hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business none

FATHER 12. Name William Milton

13. Birthplace Balto, Md

MOTHER 14. Maiden Name Florence Royston

15. Birthplace Balto Md

16 (a) Informant E. Mason Friend

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Balto County Md

18 (a) Funeral director Mrs Rosa D. Lewis Dy

(b) Address 1127 N. Lanvale

19 (a) (Date rec'd by registrar) (b)

AUG 1 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10 1948 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29 1948 to 8-10 1948 and that I last saw h She alive on 8-10 1948

Immediate cause of death

Malignant pulmonary tumor

Due to Lung Abscess

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: 8-11-48 - Shaw

Duration: 48 hrs 6 wks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D. Carr M. D.

Address 515 Walker St Date signed 8-(illegible) 48

G65861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

Registered No. G65861

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution West Balto. Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4912 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anthony, Eva L.

3 (b) If veteran, name war: W

3 (c) Social Security Account No. NONE

4. Sex: F

5. Color or race: W

6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband or wife: Roger A. Anthony

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16th 1898

8. AGE: Years 50 | Months 2 | Days 27 | If less than one day: hr. min.

9. Birthplace Frederick Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Charles Warner
13. Birthplace Frederick Md.

MOTHER
14. Maiden Name Anna Shelton
15. Birthplace Frederick Md.

16 (a) Informant Roger A. Anthony
(b) Address 4912 Reisterstown Rd.

17 (a) Burial (b) Date thereof 8/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Johnsville
Location Carroll Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1212 St. Paul St. Baltimore, Md.

19 (a) AUG 14 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 - 13 - 1948 at 1140 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9 1948 to 8-13 1948, and that I last saw her alive on 8-13 1948.

Immediate cause of death	Cardiac Failure	
Due to	Thyrotoxic Heart Disease	
Due to	Toxic nodular goitre	
Other Conditions	Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David L. Lieberstein M. D.
Address West Balto. Gen'l Hosp. Date signed 8/13/48

VS 180

G65862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65862 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town BALTIMORE #12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 6307 PINEHURST RD. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME PAUL G. BALLARD
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: LILLIAN HICKS BALLARD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 18, 1890
8. AGE: Years 58 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation ATTORNEY
11. Industry or business —

FATHER
12. Name WILLIAM C. BALLARD
13. Birthplace CHRISTFIELD, MD

MOTHER
14. Maiden Name ROBERTA FRANKLIN
15. Birthplace MARYLAND

16 (a) Informant LILLIAN HICKS BALLARD
(b) Address SAME AS DECEASED

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8/16/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address 2 E. Lanvale Ave.

19 (a) AUG 14 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 AUGUST 1948, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11:15 AM 13 AUG 48 to 1:15 PM 13 AUG 48 19; that I last saw him alive on 13 AUG 1948.

Immediate cause of death: Cardio-respiratory failure — Duration: 1 day.
Due to: Cerebral hemorrhage — 1½ days
Due to: Hypertension — ? years
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: 8/13/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald S. England M. D.
Address Maryland General Hosp. Balto. Md. Date signed 13 Aug 48

VII 193

665863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G65863

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 650 W Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Odell Young

3 (b) If veteran, name war

3 (c) Social Security Account No. 240-12-7726

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/8/1914

8. AGE: Years 34 | Months 4 | Days 28 | If less than one day - hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Robert Young
13. Birthplace N.C.

MOTHER
14. Maiden Name Lucy Holden
15. Birthplace N.C.

16 (a) Informant Lucy Stewart (Mother)
(b) Address R.F.D. Glenburnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. County, Md.

18 (a) Funeral director Charles T. Cooper
(b) Address 518 Carrollton Ave.

19 (a) AUG 14 1948 (Date rec'd by registrar) Transcribed for Indiana, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1948, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pontechial hemorrhage of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-5-48 at 9:10 P.M. 17:3
(b) Where did injury occur? Milburn & Myrtle Aves
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? not
(d) Means of injury Pedestrian struck by auto

23. Signature Earl L. Kay M.D.
Medical Examiner.
Date signed 8-6-48

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G665864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

Registered No. G658664

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Good Samaritan Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town ..... (If outside city or town limits, write RURAL and give town)
(d) Street No. Unknown (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Edgar Grimes. (GRIMES)

3 (b) If veteran, name war ..... | 3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife ..... Fate
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 1858

8. AGE: Years	Months	Days	If less than one day
90			..... hr. ..... min.

9. Birthplace ..... Maryland (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name ..... UNKNOWN
13. Birthplace .....

MOTHER
14. Maiden Name ..... UNKNOWN
15. Birthplace .....

16 (a) Informant ..... Dept. Public Welfare
(b) Address 328 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48. (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director William A. Jackson
(b) Address 946 Penna. Ave.

19 (a) AUG 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6th 1948, at 3.20 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from July 29th 19.. to Aug 5th 1948. and that I last saw him alive on Aug 5 1948.

Immediate cause of death ..... Marasmus

Due to ..... Old age

Due to .....

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration: Years.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....

23. Signature Charles Cumming M. D.
Address 910 Maryland St. Date signed Aug. 11

VS 150

162 C 1948.

65865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

G65865
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 794 W. Franklin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ERNEST Richard (Fox) FAX

3 (b) If veteran, name war: World War #I.
3 (c) Social Security Account No.

4. Sex: MALE
5. Color or race: COLORED
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 1898
8. AGE: Years 50 | Months 7 | Days | If less than one day hr. min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Waiter
11. Industry or business

FATHER
12. Name: Richard Fax
13. Birthplace: Maryland.

MOTHER
14. Maiden Name: Alice Ruff
15. Birthplace: Maryland.

16 (a) Informant: Eugene Fax
(b) Address: 794 W. Franklin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-48 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location: Baltimore, Md.

18 (a) Funeral director: William A. Jackson
(b) Address: 916 Penna. Ave. Huntington Station, Md.

19 (a) AUG 14 1948 (Date rec'd by registrar) (b) Registrar

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1948, at 3.30 P M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased died to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Rapp M.D.
Medical Examiner.
Date signed 8-14-48

65866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93)

Registered No. 65866

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 S. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 S. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18 1871

8. AGE: Years	Months	Days	If less than one day
77	-	27	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired Tailor

11. Industry or business

FATHER
12. Name John F. White
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Callan
15. Birthplace Ireland

16 (a) Informant Miss Julia White
(b) Address 5 S. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry Kleinmann
(b) Address 4204 Ridgewood Ave

19 (a) AUG 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14/48 19 , at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15/48 19 8/14/48 19 , and that I last saw him alive on 8/14/48 19

Immediate cause of death	Duration
Hypertrophy of the prostate with urinary retention.	3 yrs.
Due to	
Due to	
Other Conditions Arteriosclerotic C-V disease	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Vernon Williamson M. D.
Address 4508 Edmondson Ave Date signed 8-14-48

VS 150

Balt 29

139a

G65867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G65867 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3009 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELLEN MONITOR FOUNTAIN

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband ~~or wife~~ Charles E. F. Fountain
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 17, 1862

8. AGE: Years	Months	Days	If less than one day
86	6	24	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John B. Herold
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Hahn
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Anna E. Kunnecke
(b) Address 3009 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/48 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Baltimore
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICHNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 AUG 14 1948 (Date rec'd by local registrar) [illegible] REGISTRAR

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Past 20 years 19 to 19; and that I last saw her alive on Aug 11 1948

Immediate cause of death: Carcinomatosis

Duration: 1 yr

Due to: Ca. of breast

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 708 Med Arts Date signed 8/14/48 M.D.

VS 150

G655868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G655868

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4403 Adelle Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4403 Adelle Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flora A. Mitchell

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George Mitchell
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr: Dec. 8, 1860

8. AGE: Years 87 | Months 8 | Days 6 | If less than one day hr. / min.

9. Birthplace: Indiana (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Jacob Brandt
13. Birthplace: France

MOTHER
14. Maiden Name: Martha Britten
15. Birthplace: South Carolina

16 (a) Informant: Mrs. George Newlin
(b) Address: 4403 Adelle Terrace Balto. Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 15 1948 (month) (day) (year)
(c) Cemetery or crematory: Washington Park
Location: Indianapolis, Indiana

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: North & Pennsylvania Aves. Irvington, Indianapolis, Ind.

19 (a) AUG 14 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14, 1948, at 2.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1948 to Aug. 14 1948 and that I last saw her alive on Aug. 14 1948.

Immediate cause of death: Congestive Heart Failure — Duration: 3 wks.

Due to Arteriosclerotic Cardio-vascular Renal Disease — 16 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nelson K. Talbert M.D.
M. D.
Address Catonsville 28, Md. Date signed 8-14-48

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G65869

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

G65869 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2305 Ocala Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Ocala Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Clara Zalis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Samuel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1885
8. AGE: Years 63 | Months | Days | If less than one day: hr. min.
9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation: House wife
11. Industry or business

FATHER
12. Name: Abraham Kleiman
13. Birthplace: Russia

MOTHER
14. Maiden Name: Dina Lashbitz
15. Birthplace: Russia

16 (a) Informant: Samuel Zalis
(b) Address: 2305 Ocala Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15, 1948 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale Cem
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) AUG 15 1948 (Local registrar) by Washington Williams (Deputy)

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MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1948 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1948 to Aug 14 1948 and that I last saw h[illegible] alive on Aug 14 1948.

Immediate cause of death: Coronary Occlusion — Duration 2 days
Due to Hypertensive Cardio-Vascular disease — 4 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 7607 Wesleyan Ave Date signed Aug 14 48

G65870

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G65870 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 N. Pulaski St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4903 Palmer Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Greenberg

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Simon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia.

MOTHER
14. Maiden Name Nelki
15. Birthplace Russia.

16 (a) Informant Leon Greenberg
(b) Address 1610 N. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Rt 40 & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

AUG 15 1948 (Date rec'd by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12 1948 at 9:39 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio Respiratory Failure

Due to Cardiac Decompensation

Other Conditions Hypertension C.V.D.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D.
Medical Examiner.
Date signed 8-13-48

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G65871

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

8 2a

G65871
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Frederick Ave
(c) Hospital or institution: Colonial Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3913 Belle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rubin Katzewitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Jennie Katzewitz
(b) Address 3913 Belle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philp Rd Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 2100 Eutaw Place

19 (a) [illegible]
(b) Registered by registrar Huntington Williams M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13 1948 at 7:10 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 8-6 1948, to 8-13 1948, and that I last saw him alive on 8-13 1948

Immediate cause of death Cerebral hemorrhage — Duration about 2 hrs

Due to Cerebral Arteriosclerosis and Hypertension — Duration many years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry A. Zeitelbaum M.D.
Address 1801 Eutaw Pl. Date signed 8/13/48

G65872

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45F

G65872
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 Orleans Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL J KEELEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widow

6 (b) Name of husband ~~or wife~~ Lola Katherine Keeley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 3 1883

8. AGE: Years	Months	Days	If less than one day
65	9	11	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business Yard on Ships

FATHER
12. Name Peter Keeley
13. Birthplace Ireland

MOTHER
14. Maiden Name Hanora
15. Birthplace Ireland

16 (a) Informant Ella M. Keeley
(b) Address 3102 Kentucky Ave

17 (a) Burial (b) Date thereof Aug 17 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Old Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3600 Baltimore St

AUG 16 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1948, at 4 10 M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of throat.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Pierce M.D.
Medical Examiner.
Date signed 8 14 48

VS 181

G65873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178a

Registered No. G65873

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4611 Schenley Road
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 7 14
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4611 Schenley Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carl W. Meislahn (CARL WALTER MEISLAHN)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-20-8000

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Erma Krug Meislahn

6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.) Feb-24-1885

8. AGE: Years 63 | Months 5 | Days 21 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Architectual Examiner for

11. Industry or business: F.H.A.

FATHER
12. Name: Charles F. Meislahn
13. Birthplace: Germany

MOTHER
14. Maiden Name: Bertha Dogge
15. Birthplace: Germany

16 (a) Informant: Mrs. Erma K. Meislahn (wife)
(b) Address: 4611 Schenley Road.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof: Aug-16-48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore City.

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108-W-North-Ave.

AUG 15 1948 (Date rec'd by registrar) (b) Huntington Holliday M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION A.

20. DATE OF DEATH August 14/48 9, at 8:25 M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation due to carbon monoxide poisoning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 27/12 P.
(a) Date of injury August 13, 1948 at 4:00 M.
(b) Where did injury occur? Garage- rear of residence
(c) Did injury occur at home, on farm, industrial place, in public place? Garage While at work? No
(d) Means of injury: Motor exhaust

23. Signature: E L [illegible] M.D. (Medical Examiner)

Date signed Aug. 14/48

679524

G65874

BALTIMORE CITY HEALTH DEPARTMENT ✓ G65874 Registered No.

CERTIFICATE OF DEATH 122 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Brunt Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lewis Harris Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1947

8. AGE: Years 1 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Lewis Harris Sr.
13. Birthplace Bethune, S.C.

MOTHER 14. Maiden Name Virgie Smallwood
15. Birthplace Baltimore, Md.

16 (a) Informant: Lewis Harris Sr.
(b) Address 516 Brunt Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16, 1948
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md.

18 (a) Funeral director Holland Funeral Home
(b) Address 1631 Druid Hill Ave.

19 (a) Filed with Williams, M.D. (Date received) Registrar

AUG 15 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1948, at 8:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Upper respiratory infection

Due to: Fecal impaction
Malnutrition

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While working?
(d) Means of injury

23. Signature Emil L Rogg M.D. Medical Examiner.
Date signed Aug. 14/48

G65875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

✓ G65875

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1649 Monroe St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME George Patterson Jr.

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 706-07-4781

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	married

6 (b) Name of husband or wife Geneva Coates

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1913

8. AGE: Years	Months	Days	If less than one day hr.	min.
34	7	22		

9. Birthplace Ho Dein, Balto Co. Md.
(Town, county, and state)

10. Usual Occupation Brick molder

11. Industry or business

FATHER
12. Name George M. Patterson Sr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Estelle Page
15. Birthplace Balto Md.

16 (a) Informant Mrs. Geneva Coates Patterson
(b) Address 1649 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore, Md.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 1601 Druid Hill Ave.

19 (a) 1948 (b) Registrar Washington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH August 13, 1948, at 7:05 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Thrombosed aneurysm of coronary artery

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
Means of injury .....

23. Signature George T. Merrill M.D.
Medical Examiner.
Date signed 8/14/48

VS 151

Farber ✓

G65876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G65876

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (~~year~~ ~~month~~ or days) 2 17
(e) Length of stay in Baltimore (yrs., mos., or days) All life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 1
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Argyle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Forbes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	

6 (b) Name of husband or wife Wm. Forbes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1884

8. AGE: Years 64 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Lorenzo Buchanan
13. Birthplace Maryland

MOTHER 14. Maiden Name (unknown) Dutton
15. Birthplace Maryland

16 (a) Informant Mrs. Jennie Garrett
(b) Address 1302 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. (month) 17 (day) 1948 (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18 (a) Funeral director Mrs. George H. Hallard
(b) Address 601 Druid Hill Ave.

AUG 15 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13 1948, at 8:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1948, to 8-13 1948, and that I last saw h~~er~~ alive on 8-13 1948.

	Duration
Immediate cause of death Respiratory paralysis	
Due to Carcinoma - common bile duct	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Carcinoma common bile duct
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. S. Evans M. D.
Address Univ. Hosp. Date signed 8-14-48

VS 150

G65877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

✓ G65877 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 David Hill Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest A. Brooks.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife ELLEN D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1896

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace BALTO. MD.
(Town, county, and state)

10. Usual Occupation Dyer and Cleaner

11. Industry or business

FATHER
12. Name GEORGE BROOKS
13. Birthplace EASTON, MD.

MOTHER
14. Maiden Name JULIA CLAYTON
15. Birthplace BALTO. MD.

16 (a) Informant MRS. ELLEN A. BROOKS
(b) Address 2109 DRUID HILL AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Aug. 17, 1948 (month) (day) (year)
(c) Cemetery or crematory MT. AUBURN
Location BALTIMORE, Md.

18 (a) Funeral director Geo. A. Mullen
(b) Address 1631 Druid Hill Ave.

19 Aug 15 1948 (b) Baltimore Md
Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13 1948 at 9:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/ 1948 to 8/13 1948 and that I last saw him alive on 8/12 1948.

Immediate cause of death Uremia — Duration 4 days

Due to Hypertensive C-V Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature X. Preston Grant

Address 661 N. Carrollton Date signed 8/13/48 M.D.

VS 150

Physicians: please write the causes of death clearly and legibly.

G65878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

Registered No. G65878

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 W. Lanvale St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 69

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 W. Lanvale St.
(Rural give location) No.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H. MARTIN

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-4294

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Henrietta J. Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8, 1879

8. AGE: Years	Months	Days	If less than one day
69		2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Landryman
11. Industry or business

FATHER
12. Name Luther Martin
13. Birthplace Easton, Maryland.

MOTHER
14. Maiden Name Ellen Stokley
15. Birthplace Providence, R.I.

16 (a) Informant Mrs. Henrietta J. Martin
(b) Address 515 W. Lanvale Street

17 (a) Burial (b) Date thereof 8/13/1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Holland Funeral Home
(b) Address 1631 Druid Hill Ave.

19 (a) (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 10 1948 at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1948 to 8/10 1948 and that I last saw h[illegible] alive on 8/10 1948.

Immediate cause of death Cerebral Hemmorhage (1 Day)
Due to arteriosclerosis
Due to Chronic Myocarditis
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1111 Seel W Date signed 8/13/48

VS 150

G665879

BALTIMORE CITY HEALTH DEPARTMENT ✓ G665879
Registered No.

CERTIFICATE OF DEATH 927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution:
Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Engelbert Frhlik

3 (b) If veteran, name war — | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	W.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 25, 1875

8. AGE: Years	Months	Days	If less than one day
72 73	11	18	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Adolph Frhlik
13. Birthplace

MOTHER 14. Maiden Name Cash —
15. Birthplace

16 (a) Informant Sister Linus Fr Rose
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St.

19 (a) (Signature of person who c'd by registrar) (b) Registrar

Aug 16 1948

VS 150

Funeral for Wednesday, Aug 18

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1948, at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1948 to Aug 12 1948, and that I last saw him alive on Aug 11 1948.

Immediate cause of death	Duration
Valvular Heart disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lucas Fisher M. D.
Address 1873 N. Market St. Date signed 8/13/48

+

G65880

C No. 1202

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G65880
Registered No. 1362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 733 W. Saratoga ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Percy Bernard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 4 - 1893

8. AGE: Years	Months	Days	If less than one day
54	9	8	hr. min.

9. Birthplace N.J. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ernest Bernard
13. Birthplace N.J.

MOTHER
14. Maiden Name Mamie ?
15. Birthplace N.J.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 (month) 18 (day) 48 (year)
(c) Cemetery or crematory Newark
Location Newark, N. J.

18 (a) Funeral director Dudley R. Woodley
(b) Address 107½ N Bloomfield Ave. Irvington for Williams, Mgr.

Date rec'd by registrar 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8- 12- 1948, at 5.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7- 4- 1948 to 8- 12- 1948 and that I last saw him alive on 8- 12- 1948.

Immediate cause of death ?

Due to Pulmonary tuberculosis (?)

Duration ? yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Gayle Burton
Address Baltimore City Hospitals Date signed 8/14/48

VS 150

G65881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G65881 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or instt. (yrs., mos., or days) 4 hrs 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1165 Calhoun St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes; name country

3 (a) FULL NAME Mary Brown. (MAY)

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Fe
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single.
6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1898

8. AGE: Years 70 | Months ? | Days ? | if less than one day hr. min.

9. Birthplace Baltimore (town, county, and state)
10. Usual Occupation House Keeper.
11. Industry or business

FATHER
12. Name Timothy Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Kirby
15. Birthplace Ire.

16 (a) Informant Mrs Sara McConnell
(b) Address 116 S. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/98 (month) (day) (year)
(c) Cemetery or crematory H. Lutheran Cem.
Location Balto. Md

18 (a) Funeral director Geo. E. Boyd
(b) Address 512 Hollins St.

19 (a) Received by (Registrar) 1998 (b) Transcription Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13-1898, at 2.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12-98 to 8-13-98, and that I last saw her alive on 8-13 1898.

Immediate cause of death: cerebro-vascular accident — Duration: unk.
Due to: hypertensive heart disease — unk.
Due to:
Other Conditions: cardiac decompensation, moderate — unk.
(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman V. Keane. M.D.
Address Franklin Sq. Hosp. Date signed 13 Aug 98

(Norman V. Keane)

65882

BC-C 3647

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

78B

Registered No. C65882

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Redwood Sts.
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Johnson

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None.

4. Sex: Male
5. Color or race: Negro.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: none.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) ?
8. AGE: Years 2½. Months Days If less than one day hr. min.
9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation infant
11. Industry or business 0

FATHER
12. Name James Johnson.
13. Birthplace Timmonsville. S.C.

MOTHER
14. Maiden Name Bessie Brown
15. Birthplace Timmonsville S.C.

16 (a) Informant James Johnson.
(b) Address 1102 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location West Park, Balto. Md.

18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 922 N. Mount St.

19 AUG 16 1948 (Date rec'd by registrar) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1948, at 5:10 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1948, to Aug 14 1948, and that I last saw him alive on Aug 14 1948.

	Duration
Immediate cause of death Respiratory failure	
Due to Lead encephalitis	
Due to	
Other Conditions pneumonia right base.	over

(Include pregnancy within 3 months of death)

Date of operation None.
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Patterson Mack (M. D.)
Address University Hospital Balto. Maryland. Date signed 8-14-48

VS 190

665883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 665883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address South Balto. General Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Cereal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Kasuba Dominic Kaszubinski

3 (b) If veteran, name war

3 (c) Social Security Account No. 215077091

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lottie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Crane Operator

11. Industry or business Davidson Chem. Co.

FATHER
12. Name John
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Lottie Kaszubinski
(b) Address 1621 Cereal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross A.A.Co.
Location Baltimore

18 (a) Funeral director Fred W Ozarzuk
(b) Address 1930 Eastern Ave.

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Huntington Nicholas M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 14, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from AUGUST 13 1948 to AUGUST 14 48 and that I last saw him alive on AUGUST 14 48.

Immediate cause of death	Duration
MASSIVE CEREBRAL HEMORRHAGE	
Due to CEREBRAL SCLEROSIS	
Due to ARTERIOSCLEROTIC HEART DISEASE	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel P. Scalia
Address South Baltimore Gen. Hosp. Date signed 8/14/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G65884

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 27 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4131 Mayx Ave 26 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME PEARLE A. SEELYE

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife Henry E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10 1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70	9	4		

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Henry Austin
13. Birthplace Erie, Penna.

MOTHER
14. Maiden Name Sally Rice
15. Birthplace Kentucky

16 (a) Informant Mrs. Lois Y. Dallmus
(b) Address 915 Cator Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto

18 (a) Funeral director L. D. Luck
(b) Address 5305 Harford Rd.

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Huntington for Williamson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 14 1948 at 1 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8 July 1948 to 14 Aug 1948 and that I last saw HER alive on 14 Aug 1948.

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Cachexia	
Due to Widespread Abdominal Carcinomatosis - Primary site undetermined	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
Epidermoid abdominal carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald F England M.D.
Address Maryland General Hospital Date signed 14 Aug 48

VS 150

G665885

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G665885

Registered No. 518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital, Balto., Md. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Harview Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry John Schwartz

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lottie Burdette
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) June 22, 1892

8. AGE: Years 56 | Months 1 | Days 21 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Meat Salesman
11. Industry or business:

FATHER
12. Name: William Schwartz
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Barbara Bien
15. Birthplace: Baltimore, Md.

16 (a) Informant: Records
(b) Address: U.S. Marine Hospital, Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/48 (month) (day) (year)
(c) Cemetery or crematory: Balto National
Location: Balto
18 (a) Funeral director: L. D. Luck
(b) Address: 5305 Harford Rd
19 AUG 16 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1948, at 9:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1948 to August 13 1948, and that I last saw him alive on August 13 1948.

Immediate cause of death: Metastatic adenocarcinoma, lymph nodes, retroperitoneal, mediastinal, supraclavicular region, and adrenal glands, vertebral column; — Duration: 3 years
Due to primary site probably prostate gland
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury J. F. VAN ACKEREN

23. Signature M. D.
Address Marine Hospital, Balto Date signed 8-13-48

VS 193

Dr. Haase
G65886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

G65886
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2709 Overland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2709 Overland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET IRENE CZARNOWSKY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Herbert Francis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21. 1885

8. AGE: Years	Months	Days	If less than one day
62	9	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Charles Soistmann
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Ficke
15. Birthplace Md.

16 (a) Informant Mr. Francis Czarnowsky
(b) Address 2709 Overland Avenue 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) AUG 15 1948 Washington [illegible], Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12, 1948 at 9:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948, to Aug. 12 1948, and that I last saw her alive on Aug. 11 1948.

Immediate cause of death Uremia — Duration 9 hrs.

Due to Ca of the Cervix c Deep pelvic infiltrations and ureteral obstruction Cachexia

Other Conditions Extreme Cachexia and emaciation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Biopsy, radium and deep x-ray therapy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature J. Harry Haase M.D.
(M. D.)
Address 4718 Harford Rd. Date signed 8/13/48

VS 150

G65837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G65887 Registered No.

A64321 12

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Alice ANNA, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Erauth

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-26-41

8. AGE: Years	Months	Days	If less than one day
6	7	19	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Frank Erauth
13. Birthplace Md.

MOTHER 14. Maiden Name Stella Sobus
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-48 (month) (day) (year)
(c) Cemetery ~~Cremation~~ St Stanislaus
Location Baltimore Md

18 (a) Funeral director George A. Weber
(b) Address 705 So. Ann St

19 (a) AUG 16 1948 (Date received by Registrar) (b) Huntington for Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-14- 1948 at 1-55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21-1948 to 8-14 1948 and that I last saw him alive on 8-13 1948

Immediate cause of death Convulsions — cerebral injury — Duration

Due to Tetanus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-22-48 Tracheotomy

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, place)
(e) Means of injury

23. Signature A. C. Fong M D
Address JOHNS HOPKINS HOSPITAL Date signed

VS 150

X

665888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 665888

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 E. Carey St.
(c) Hospital or institution:
Good Samaritan Home 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 S. High St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Younger or Oliver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late Charles Younger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31 1877

8. AGE: Years 70 | Months 7 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Oliver
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Duffy
15. Birthplace Baltimore Md

16 (a) Informant: Margaret Cherigo
(b) Address 312 Albemarle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 17/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Fraulk Sollenberger
(b) Address 2[illegible] S. High St.

19 (Date rec'd by registrar) AUG 16 [illegible] (Registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6/48 19 to 8/14 19 48.
and that I last saw him alive on 8/6 19 48.
Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Thompson M.D.
Address 628 E. N. Ave. Date signed 8/15/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G65889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 927 Abbott Court
(c) Hospital or institution: 10-

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Abbott Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Dorsey

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 19, 1886

8. AGE: Years 61 | Months 11 | Days 25 | If less than one day ########## min. 27

9. Birthplace Baltimore County (Town, county, and state)

10. Usual Occupation Practical Nurse

11. Industry or business

FATHER
12. Name James W. Dorsey
13. Birthplace Baltimore County

MOTHER
14. Maiden Name Catherine Burns
15. Birthplace Ireland

16 (a) Informant Miss. Margaret J. Dorsey
(b) Address 927 Abbott Court, Balto: Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) AUG. 16 1948 (b) Huntington Ave Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15th, 19 48 at 5 35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 19 48 to Aug. 12 19 48
and that I last saw h alive on Aug. 12, 19 48

Immediate cause of death Hypertension
Cardio-Vascular Disease.

Duration 13 years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Summerville
Address Medical Arts Bldg Date signed 8/16/48

V S 150

Please fill in completely. Physicians: please write the causes of death clearly and legibly.

5890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G65890 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N.Broadway
(c) Hospital or institution: Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 dys
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 E. Lanvale St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alphonse Hentschel (Alphonse J.Hentschel)

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 215-09-7103

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Hentschel (Anna M.Weipert)

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Jan 2 1895

8. AGE: Years (53) 53 | Months 6 | Days 23 | If less than one day: ##### min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Mechanist

11. Industry or business American Can Co.

FATHER
12. Name Paul Hentschel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Rolle
15. Birthplace Germany

16 (a) Informant Mrs.Anna M.Hentschel (Wife)
(b) Address 1620 E.Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.Balto:Md.

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1235 Harford Avenue,Balto:Md.

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Washington Wilcox Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1948 at 9:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/7 1948 to 8/14 1948 and that I last saw h alive on 8/14 1948.

Immediate cause of death: Cardiac Failure — Duration
Due to: Coronary Thrombosis
Due to: Arteriosclerosis
Due to: (a) & (b)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D.W.Monk M. D.
Address Church Home Date signed 8/14/48

VS 150

X

65891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓

G65891 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1428 E Lanvale St.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1428 E Lanvale St. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha R. Joesting (Bertha R. Joesting)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles F. Joesting

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1882

8. AGE: Years 66 | Months 6 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William Dukehart
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rachel Young
15. Birthplace Baltimore, Md.

16 (a) Informant William R. Dukehart
(b) Address 1428 E. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Frances [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14 1948, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio Respiratory Failure

Due to Coronary Heart Disease

Other Conditions Arteriosclerosis Generalized
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. Maddox M.D. Medical Examiner.
Date signed 8-15-48

VS 181

X

5892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 665892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Avenue
(c) Hospital or institution:
Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Weldon Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Kalbfus

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Kalbfus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) September 7, 1861

8. AGE: Years 86 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Fireman Union Trust Co.

11. Industry or business Retired 20 years

FATHER
12. Name John Kalbfus
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Ann Stites
15. Birthplace Maryland

16 (a) Informant Mrs. Katie E. Dosh
(b) Address 1325 Weldon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 17, 1948 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) AUG 16 1948 (Date received by registrar) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1948, at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1941 to July 14 1945. and that I last saw h alive on

Immediate cause of death: Congestive Heart Failure — Duration

Due to: Arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward L. Kerrmann M. D.

Address 2015 Eutaw Pl. Date signed 7/6/48

VS 193

X

GM. G65893 110822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65893

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Year
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 Ainquith ST. Z 3
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Lightner or Annie Leightner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17- 1916

8. AGE: Years	Months	Days	If less than one day
32	1	25	hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Brown
13. Birthplace S.C.

MOTHER
14. Maiden Name Alice Glayden
15. Birthplace S.C.

16 (a) Informant records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16-48 (month) (day) (year)
(c) Cemetery or crematory Secrest Parken Memorial Gardens
Location Winsboro S.C.

18 (a) Funeral director Elroy O. Ellison
(b) Address 1210 Edmondson Ave

AUG 16 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8- 12- 1948, at 6.35P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5- 21 -1947 to 8- 12- 1948, and that I last saw her alive on 8- 12- 1948

Immediate cause of death Massive pulmonary hemorrhage — Duration 15 min.

Due to Far advanced pulmonary tuberculosis & cavitation-bilateral — Duration 18 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M. D.
Address Balto. City Hospitals Date signed 8-13-48

VS 193

G65894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

G65894

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Pulaski Sts
(c) Hospital or institution:
Bon Secours Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Bond St., Balto, Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Mrs. Anna Rogalski Puncochar

PUNCOCHAR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Frank Puncochar
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr) April 5, 1913

8. AGE:

Years	Months	Days	If less than one day
35	4	9	..... hr. ..... min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Vincent Rogalski
13. Birthplace Poland

MOTHER
14. Maiden Name Teresa Dabrunek
15. Birthplace Czechoslovakia

16 (a) Informant Frank Puncochar
(b) Address 1602 Bond St., Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) Date received by registrar (b) Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1948 at 8:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1948, to Aug. 14 1948, and that I last saw her alive on Aug 14 1948.

Immediate cause of death Bilemia → Duration 6 wks.?

Due to Hepatic cirrhosis 6 mo.?

or

Due to Cancer of the pancreas 6 mo.?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter B. Sanger, M. D.
Address Bon Secours Hospital Date signed Aug 14, 1948.

X

G65895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G65895

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 Gorgas Ct.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) about 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Gorgas Ct.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Stella Louise B. Woodall

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife William B. Woodall
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) May 9, 1887

8. AGE: Years 61 | Months 3 | Days 6 | If less than one day: hrs. min.

9. Birthplace Ottawa, Ontario Prov. Canada
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Joseph Billyard
13. Birthplace Canada

MOTHER
14. Maiden Name Mitchell (?)
15. Birthplace Canada

16 (a) Informant Wm. B. Woodall (Husband)
(b) Address 1128 Gorgas Ct. Balto. 30, Md.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Aug. 18-1948 (month) (day) (year)
(c) Cemetery or crematory London Park, Balto, Md.
Location Edmondson Ave.

18 (a) Funeral director Frank J. Charlton Balto 30, Md.
(b) Address

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Evelyn Williams, Md. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sun. 15 August 1948, at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Vascular Accident

Due to —

Other Conditions Fracture, old, left hip
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Wm. H. Kammerer, Jr. M.D.
Medical Examiner.
Date signed 15 Aug. 48

G65896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G65896 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3218 Gwynn Falls Pkwy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3218 Gwynn's Falls Pkwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine C. Blank

3 (b) If veteran, name war —
3 (b) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11 1871

8. AGE: Years	Months	Days	If less than one day
76	9	2	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frederick Blank
13. Birthplace Germany

MOTHER
14. Maiden Name Rose A. Eyle
15. Birthplace Germany

16 (a) Informant Miss Josephine Blank
(b) Address 3218 Gwynn's Falls Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location A.A. Co. Md.

18 (a) Funeral director Tilyou & Fleming
(b) Address 1476 Eutaw St.

AUG 16 1948 (b) Registrar
Date filed by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13 1948, at 11 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1947 to Aug 13 1948, and that I last saw h[illegible] alive on Aug 13 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 min.
Due to Hypertensive Cardio-Vascular disease	10 yrs.
Due to	
Other Conditions Epilepsy	3 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Robertson M. D.
Address 2835 Eutaw Pl. Date signed 8/13/48

VS 150

G65897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G65897 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3129 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3129 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES J. FARRELL

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1898

8. AGE: Years	Months	Days	If less than one day: hr.	min.
50				

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chemist
11. Industry or business

FATHER
12. Name James J. Farrell, Sr.
13. Birthplace Baltimore

MOTHER
14. Maiden Name A. Forestall
15. Birthplace Baltimore

16 (a) Informant Mrs. G. Farrell
(b) Address 2110 Boone St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director WIEDEFELD & SON
(b) Address Greenmount Ave & 22nd.

AUG 16 1948
(Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12/48 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11/48 19 to 8/12/48 19, and that I last saw him alive on 8/12/48 19

Immediate cause of death: Coronary Thrombosis — Duration: sudden
Due to
Due to
Other Conditions Ac, Fibrous Pleurisy — 3 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature F. B. Culverhouse M.D.
Address 1901 Eutaw Place, City Date signed 8/13/48

G65898

BALTIMORE CITY HEALTH DEPARTMENT ✓ G65898

CERTIFICATE OF DEATH 186

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose ave
(c) Hospital or institution: Ardleigh Nursing Home also Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Hosp
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Co
City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anastasia Thomazos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Eustratios
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Kanicolas
13. Birthplace Greece

MOTHER
14. Maiden Name
15. Birthplace Greece

16 (a) Informant Stephen Hayes
(b) Address 1903 W Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 16 48 (month) (day) (year)
(c) Cemetery or crematory Greek Com.
Location Windsor Mill Rd

18 (a) Funeral director Lambros Fun. Hom Inc
(b) Address 440 E North ave

19 (a) 8 16 1948 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to Aug 13 1948, and that I last saw her alive on Aug 13 1948.

Immediate cause of death	Duration
Myocardial Insufficiency Edema	
Due to Arteriosclerotic Coma	
Due to Cancer	
Other Conditions Fractured neck of femur	2 wks

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 2011
(a) Accident, suicide, or homicide Fracture Complicated
(b) Date of occurrence Aug 13 1948 at 2 P M
(c) Where did injury occur? 1903 W. Franklin St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? —
(Specify type of place)
(e) Means of injury Fall while walking

23. Signature [illegible] M. D.
Address 342 N Pleasant St Date signed 8/16/48

VS 11

G. H. Merrill MD

G65899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No. G65899

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3116 Presbury St.
(c) Hospital or institution: -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 - 6
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or ~~town~~ Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Presbury st.
(If rural give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country -

3 (a) FULL NAME FRANCES E. FISHER nee RANDLE

3 (b) If veteran, name war: No

3 (c) Social Security Account No.:

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married,~~ widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or ~~wife~~: Raymond Fisher

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): MAR. 27, 1888

8. AGE: Years: 60 | Months: 4 | Days: 18 | If less than one day: 19 hr. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Burper

11. Industry or business: Canton

FATHER
12. Name: Joseph Randle
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Margaret Winters
15. Birthplace: Maryland

16 (a) Informant: Mrs. P. Raymond Transfelter
(b) Address: 5619 Edmondson Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 8/19/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~: Loudon Park
Location: Balto., Md.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: Death & Po. Ave.

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) ~~Number~~ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1948, at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948. to Aug. 15 1948. and that I last saw her alive on Aug. 15 1948.

Immediate cause of death: Carcinoma of liver — Duration: about 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation March 29, 1948

Major findings of operation: Carcinoma of liver

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Geo J. Gover M.D. M. D.

Address: 1 Mallow Hill Ave Date signed: 8/16/48

Baltimore, Md

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G65900
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave.
(c) ~~Hospital~~ or institution:
R. D. Wilson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County -
(c) City or ~~town~~ BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 BOLTON ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES EDGAR TOMPKINS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: widowed
6 (b) Name of ~~husband~~ or wife: Mary L. Tompkins NEE - McCORT
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr): April 15, 1867
8. AGE: Years: 81 | Months: 4 | Days: - | If less than one day: hr. min.
9. Birthplace: Clarkstown, N. Y. (Town, county, and state)
10. Usual Occupation: Printer
11. Industry or business: Retired

FATHER
12. Name: Sidney B. TOMPKINS
13. Birthplace: New York

MOTHER
14. Maiden Name: MARY H. YOCUM
15. Birthplace: New York

16 (a) Informant: Mr. Raymond L. Tompkins
(b) Address: 5407 Falls Rd. Terrace

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 8/17/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~: Lorraine
Location:

18 (a) Funeral director: Wm J. Tickner & Sons
(b) Address: North & Pa. Aves.

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1948, at 5:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1948, to Aug. 16 1948, and that I last saw him alive on Aug. 14 1948:

Immediate cause of death: Carcinoma of Lung — Duration: 6 mo.?

Due to:

Due to:

Other Conditions: Senility; Myocardial failure.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Robt. B. Wright M. D.
Address: Medical Arts Bldg. Date signed: 8/16/48

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G65901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 43

G65901

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 N Pennington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 N. Pennington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Anne Floot

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married (or, if married, of what husband or wife)

6 (b) Name of husband or wife John J. Floot

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/18/1870

8. AGE: Years 77 | Months 10 | Days 26 | If less than one day hr. min. 25

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business house work at home

FATHER
12. Name Joseph Creamer
13. Birthplace Baltimore

MOTHER
14. Maiden Name Cath Drager
15 Birthplace Baltimore

16 (a) Informant Mr Freeman Blair
(b) Address 812 Woodington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director J. Zaleski Sons
(b) Address 1318 Light

19 (Date rec'd by registrar) AUG 16 1948 (Signature of Registrar) Washington for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1948, at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1944 to Aug 13 1948, and that I last saw her alive on Aug 13 1948.

Immediate cause of death	Duration
cerebral thrombosis	4 days
Due to cerebral arteriosclerosis	3 years
Due to generalized arteriosclerosis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur a. ome, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. A. Kemp
Address 3030 Edmondson Ave Date signed 8/14/48 D

VS 199

G65902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G65902

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11-
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Orchard Street (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Eva Crofton

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 421-07-9998

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1898

8. AGE: Years 49 | Months 10 | Days 5 3 | If less than one day ..... hr. ..... min.

9. Birthplace Ashby, Alabama (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business .....

FATHER
12. Name Winston Evans
13. Birthplace Alabama

MOTHER
14. Maiden Name Rachel Allen
15. Birthplace Alabama

16 (a) Informant Stanley Crofton
(b) Address 402 Orchard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/48 (month) (day) (year)

(c) Cemetery or crematory .....
Location Evergreen, Ala.

18 (a) Funeral director Charles S. Law
(b) Address 402 Pennsylvania Ave., Baltimore, Md.

19 (a) AUG 16 1948 (b) ..... (Date rec'd by local Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8, 1948, at 1:30A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature [signature] M.D.
Medical Examiner.

Date signed 8 Aug 48

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 437

Registered No. G65303

65903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3907 Hudson St.
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Hudson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLINE WILHELMINA CHARLOTTE CADDELL

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Thomas W. Caddell

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Feb. 2. 1871

8. AGE: Years 77 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Willner
13. Birthplace Germany

MOTHER
14. Maiden Name Eva Barbara Wehr
15. Birthplace Germany

16 (a) Informant Mr. Irwin Caddell (Son)
(b) Address 307 S. Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 17. 1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Baltimore

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Filed for Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13. 1948 at 8.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1948 to Aug 13 1948 and that I last saw h[er] alive on Aug 13 1948

Immediate cause of death: Cerebral Hemorrhage — Duration 5 days
Due to: Arteriosclerosis
Due to: Cardiac Vascular disease
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. B. Stevens M.D.
Address 3400 Ednor Rd Date signed 8/14/48

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L. B. Stevens

G65304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G65904

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Mt. Holly St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Georgiana Covell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William B. Covell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30, 1865

8. AGE: Years	Months	Days	If less than one day
82, 83	10	15th	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Thomas J. Ward

13. Birthplace Md.

MOTHER 14. Maiden Name Martha Nickalson

15. Birthplace Md.

16 (a) Informant Carroll S. Covell

(b) Address 301 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17-1948 (month) (day) (year)

(c) Cemetery or crematory London Park

Location 3501 Frederick Ave

18 (a) Funeral director Mrs. John H. Diehl Son

(b) Address 2311 Edmondson Ave

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1948, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1948 to August 14 1948, and that I last saw h alive on August 14 1948.

	Duration
Immediate cause of death Myocardial Degeneration + insufficiency	6 months
Antecedent causes Arteriosclerosis and Hypertension Type of Heart disease	6 years
Due to Chronic Interstitial Nephritis	4 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Trichet M. D.

Address 2901 Edmondson Ave Date signed Aug 15 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

G65905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 121 ✓

Registered No. G65905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. Riviera Beach
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Carrie Phelps

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 1, 1889

8. AGE: Years	Months	Days	If less than one day
63	10	13	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name August Weaver
13. Birthplace Baltimore

MOTHER
14. Maiden Name Caroline Zink
15. Birthplace Pa.

16 (a) Informant GEORGE C. PHELPS
(b) Address 200 E. DORIS AVE -25

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8/17/48 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST - 30

19 (a) AUG 16 1948 (Date rec'd by registrar) (b) Transcription from Millington, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1948, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7 1948 to 8/14 1948, and that I last saw h[illegible] alive on 8/14 1948.

Immediate cause of death Paralytic ileus

Due to Ruptured Gangrenous appendicitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Adynamic ileus

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Lavanny, M.D.
Address Md. Gen. Hosp. Date signed 8/17/48

VS 1-50

C65906

E5-92463

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

110 B

Registered No. C65906

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals. 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs. 5 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Friendly Inn, Sharp St. (If rural give location) 207 E. Sharp St.
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Webb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1875?

8. AGE: Years	Months	Days	If less than one day
72?	7	21	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Records- Balto. City Hospitals.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 8/17/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md

18 (a) Funeral director William Fox Sr.
(b) Address 2197 Pont St.

19 AUG 16 1948 (b) Registrar Washington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15 1948, at 11 AM

21. I certify that death occurred on the date above stated: that I attended deceased from 3-8 1945 to 8-15 1948, and that I last saw him alive on 8-15 1948

Immediate cause of death Congestive heart failure - Cerebral edema and Cerebral Thrombosis

Duration

Due to -

Due to -

Other Conditions Arteriosclerosis general

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Warren E. Porter M.D.
Address Date signed 8/16/48

VS 150

63907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. G65907

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1955 Perlman Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1955 Perlman Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Leahill
3 (b) If veteran, name war
3 (c) Social Security Account No. 211-07-2144

4. Sex	5. Color or race	6 (a) ~~Single~~, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 8th 1898

8. AGE: Years	Months	Days	If less than one day
49	8	6	hr. mi.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Leahill
13. Birthplace Md

MOTHER
14. Maiden Name Clara Mershman
15. Birthplace Md

16 (a) Informant Mrs. Leahill
(b) Address 1955 Perlman Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17th 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave Ext

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N. Patterson Park ave

19 AUG 16 1948 (b) Huntington Williamsport Md
(Not to be filled in by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1948, at 4:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1948, to Aug 14 1948, and that I last saw h alive on Aug 13, 1948

Immediate cause of death: Terminal pneumonia — Duration: 1 day

Due to Carcinoma of Kidney (left) — ?

Secondaries everywhere

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Early July 1948

Major findings of operation: Carcinoma of Left Kidney

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Silberfeld M. D.
Address 714 E. Preston St Date signed Aug 19

Samuel Silberfeld

VS 153

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

665908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

Registered No. 665908

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. Balto. Gen'l. 15
D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Uttermahlen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18 - 1884

8. AGE: Years 54 | Months 6 | Days 28 | If less than one day hr. 14 min. 44

9. Birthplace Carroll County, Md
(Town, county, and state)

10. Usual Occupation Sales Store

11. Industry or business Operator

FATHER
12. Name Henry Uttermahlen
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Humbert
15. Birthplace Maryland

16 (a) Informant Mrs. C. L. Wolfe
(b) Address Union Bridge, Md. R.D.

17 (a) Burial (b) Date thereof 8/19/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baust Cemetery
Location Taneytown Road

18 (a) Funeral director H. H. Hartzler & Sons
(b) Address Union Bridge & Uniontown, Md.

AUG 16 1948
(Date received by registrar)

(b) Uniontown, Md.
Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH August 15/19 48 at 8:51 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of Skull
Intracranial Hemorrhage

Due to Intracranial

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 178
(a) Date of injury August 16/48 at 8:35 A. M. M.
(b) Where did injury occur? Clifton & Allendale
(c) Did injury occur at home, on farm, industrial place, in public place? Street intersection (While at work?) No
(d) Means of injury Struck by streetcar

23. Signature [signature] M.D.
Medical Examiner.
Date signed 8-16-48

VS 181

G65909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G65909
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Saint Joseph's Hospital 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 W. Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Suddie Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1878

8. AGE: Years 70 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Marsh Wilson
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Ann Scherrer
15. Birthplace N. C.

16 (a) Informant Hester Barnard
(b) Address 1419 Federal St

17 (a) Remove (Burial, cremation, or removal) (b) Date thereof Aug 16 48

(c) Cemetery or crematory
Location Camden Cem. N. C.

18 (a) Funeral director Mrs Rose Elliott Day
(b) Address 1129 N. Carrollton St

19 (a) (b) Indianola, Miss.
(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 48 at 5:45 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Ewell Rouse M.D.
Medical Examiner.
Date signed Aug. 14/48

Correct age is especially important. Paymasters: please write the cause of death clearly and legibly.

LVS 187

G65910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G65910 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Parkman Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Parkman Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Popp

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Barbara Popp

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) February 24, 1870

8. AGE: Years 78 | Months 5 | Days 2221 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Cooper

11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant John Popp
(b) Address 130 Parkman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director George L. Wood
(b) Address 2101 Frederick Ave.

19 (a) Date received AUG 16 1948 (b) Registrar Washington Nelson

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1948 at 4:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24/47 19 to 8/15/48 19
and that I last saw him alive on 8/2/48 19

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clifton Mowbray M.D.

Address 2411 Washington Blvd. Date signed 8/16/48
M. D.

2411 WASHINGTON BLVD.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83c

Registered No. GG5911

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 Brooks Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mon., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Brooks Lane
(If rural give location)
(e) Citizen of foreign country? Belt St (Yes or No)
If yes, name country

3 (a) FULL NAME Lucinda V. Magers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife James L. Magers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4th 1862

8. AGE: Years	Months	Days	If less than one day
86	4	11	hr. min.

9. Birthplace Mt. Airy Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Thomas Harris
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Chas. E. Magers
(b) Address 1819 Belt St.

17 (a) Burial (b) Date thereof 8/18/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Pinehurst Grove United Brethren
Location Raywille Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

AUG 17 1948
(Date rec'd by Registrar) (By)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15th 1948 at 9:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22/ 1948, to 8/13/ 1948, and that I last saw h[illegible] alive on 8/13/ 1948.

Immediate cause of death Encephaloquadiarisor

Due to Arteriosclerosis

Due to

Other Conditions Bilateral cataract Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration
5 mths

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Weidenger M. D.
Address 912 Brooks Lane Date signed 8/17/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

5912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No. C65912

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 North Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ada AGUINAGA (ANNA AGUINAGA)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Edward Aguinaga
6 (c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): August 25, 1904

8. AGE: Years	Months	Days	If less than one day
43	11	22	hr. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation: Restaurant
11. Industry or business: 707 S. Broadway

FATHER
12. Name: ? Goldberg
13. Birthplace: Russia

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Russia

16 (a) Informant: Mr. Edward Aguianga
(b) Address: 1813 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 AUG 17 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15, 1948, at 4:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture 9-10 Dorsal Vertebrae

Due to

Other Conditions: 2nd + 3rd Degree Burns 1/3 Body Surface (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: August 15, 1948 Approx. 4:30 A.M.
(b) Where did injury occur? 1813 N. Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury: Jumped from 3rd fl. window because of a fire at the house

23. Signature: [signature] M.D. Medical Examiner
Date signed: 8-16-48

G65913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G65913

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1335 Gorsuch Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1335 Gorsuch Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIUS HENRY HARRINGTON

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Daisy Bedsworth

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 18. 1869

8. AGE: Years 78 | Months 11 | Days 28 29 | If less than one day: hr. min.

9. Birthplace Bivalve - Md. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Beecham Harrington
13. Birthplace Bivalve Md.

MOTHER
14. Maiden Name Deal ?
15. Birthplace Maryland

16 (a) Informant Harlan S. Harrington
(b) Address 1356 Gorsuch Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19. 1948 (month) (day) (year)
(c) Cemetery or crematory Bivalve Cemetery
Location Bivalve Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

19 (a) AUG 17 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16. 1948 at 5.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2, 1948 to Aug 16 1948 and that I last saw him alive on Aug 15 1948.

Immediate cause of death: Myocarditis — Duration: 1 yr.
Due to
Due to
Other Conditions Cerebral arterio Sclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lauretta Fasbender M. D.
Address 1823 N. Arlington Ave. Date signed 8/16/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65914

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State NJ (b) County
(c) City or town Haddonfield (If outside city or town limits, write RURAL and give town)
(d) Street No. 133 Chestnut Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter V. Moore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Grace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-11-1900

8. AGE: Years	Months	Days	If less than one day
47	8	6	hr. min.

9. Birthplace Philadelphia Pa. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Harris Moore
FATHER 13. Birthplace NJ

MOTHER 14. Maiden Name Edwards
MOTHER 15 Birthplace Ohio

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20 (month) (day) (year)
(c) Cemetery or crematory Harleigh Cem
Location Camden NJ

18 (a) Funeral director Chas. P. Tossell
(b) Address 2107 Delaware Ave Camden NJ

19 AUG 17 1948 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17 1948 at 3:02 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1948 to 8-17 1948, and that I last saw him alive on 8-17 1948.

Immediate cause of death Myocardial infarction, acute, posterior, c
pulmonary edema, acute
Due to Arteriosclerotic Cardiovascular
Due to Disease, coronary artery
insufficiency
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman E. Starrer M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 8-17-48

Norman E. Starrer

5915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 065915

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 576 N Monroe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 576 N. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dennis J. Horan

3 (b) If veteran, name war None

3 (c) Social Security Account No. 077-05-5701

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret Edna C. Horan

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Feb 15 1888

8. AGE: Years 60 | Months 6 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace (City or town, county, and state) Marlborough N.Y.

10. Usual Occupation Salesman

11. Industry or business Shoe

FATHER 12. Name John Horan

13. Birthplace

MOTHER 14. Maiden Name Catherine McCourt

15. Birthplace Pickell

16 (a) Informant Edna C. [illegible]

(b) Address 576 N. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19 1948 (month) (day) (year)

(c) Cemetery or crematory Philadelphia Penna

Location

18 (a) Funeral director Roll C. A. M. Walker

(b) Address Pratt & Stricker Sts

19 (a) AUG 17 1948 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1948, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1947 to Aug 16 1948, and that I last saw h/ alive on 8/12 1948.

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration ? ,

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. C. Wallace Langrehr M. D.

Address 400 N. Payson St Date signed 8/16/48

D. C. Wallace Langrehr X

VS 150

65916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G65916

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 129 S. Wolfe St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 S. Wolfe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis B. HURWITZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1903

8. AGE: Years 44 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Isaac Hurwitz
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Chesler
15. Birthplace Russia

16 (a) Informant James J. Hurwitz
(b) Address 2336 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Philadelphia Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

AUG 17 1948 (Date rec'd by registrar) Hyman Hillman, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1948, at 1:10 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis
Acute pulmonary edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Louis B. Hurwitz M.D. Medical Examiner
Date signed 8-16-48

66-917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 66-917

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3402 E Balto St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(c) Street No. 3402 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E Lambert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John M Lambert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28 1865

8. AGE: Years 79 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name August Hagemeier
13. Birthplace Ger

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Lilian Hamm
(b) Address 524 N Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19 48 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Balto

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Oakmont St

19 AUG 17 1948 (Date received by Registrar) (b) Timothy F. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1948, at 2 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946, to Aug 15 1948.
and that I last saw h alive on 8/15 1948.

Immediate cause of death: Cardiac Asystole

Due to

Due to

Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M H Gordon
Address 3402 E Balto Date signed 8/16/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS 150

83a

G65918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65918
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos. 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(c) State Md. (b) County Balto.
(c) City or town Deer Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lutherville, Post Office
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME H. Marshall Fritz
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W
6 (b) Name of husband or wife Elizabeth Musgrave
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) don't Know
8. AGE: Years 89 | Months | Days | If less than one day ____ hr. ____ min.
9. Birthplace Liberty, Frederick, md (Town, county, and state)
10. Usual Occupation Retired Laborer
11. Industry or business

FATHER
12. Name Mathias Fritz
13. Birthplace Dont Know

MOTHER
14. Maiden Name Julia Zepp
15. Birthplace dont Know

16 (a) Informant Earl Zepp
(b) Address Reisterstown, md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 15 '48 (month) (day) (year)
(c) Cemetery or crematory Reisterstown M.E.
Location Reisterstown, md
18 (a) Funeral director Wm. Berryman & Sons
(b) Address Reisterstown, md
19 (Date rec'd) AUG 17 1948 (Registrar) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1948 at 4:45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1948 to 8-15-1948 and that I last saw h[illegible] alive on Aug. 10 1948.

Immediate cause of death Myocarditis
Chronic decompensation
Due to Hypertension
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration 2 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible]
Address Reisterstown Md. Date signed 8-16-48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 3

5319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 665919

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Belvieu Home for Aged 27-19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvieu Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Isaac Goldberg

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Widower

6 (b) Name of husband or wife Sola
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Nathan Warden
(b) Address 2248 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Rd Rd & Hamilton Ave

18 (a) Funeral director Frank Lewis Inc
(b) Address 2100 Eutaw Pl

19 (a) AUG 17 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 - 1948, at 11 50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1948 to August 16 1948, and that I last saw him alive on 8-16 - 1948.

Immediate cause of death: Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome J. Blumberg M. D.
Address Levindale Home Date signed 8-16-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C65920

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Norfolk Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Sindler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Barney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 54 | Months | Days | If less than one day: hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name L. M. Gasker
13. Birthplace Lith

MOTHER: 14. Maiden Name Lillean Lotz
15. Birthplace

16 (a) Informant Barney Sindler
(b) Address 3902 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Road

18 (a) Funeral director Jack R. Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) AUG 17 1948 (Date rec'd by Registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15 1948, at 9.08 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1948, to 8-15 1948, and that I last saw her alive on 8-15 1948.

Immediate cause of death: Coronary occlusion — Duration

Due to

Due to

Other Conditions Hypertension kidney and Gall stones
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Gaber M. D.
Address Sinai Hosp. Date signed 8-15-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly

5921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48

Registered No. 085921

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1002 S. CONKLING ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 S. CONKLING ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD L. GOCHENOUR

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-18-39.

8. AGE: Years	Months	Days	If less than one day
9	0	27	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation CHILD.
11. Industry or business

FATHER
12. Name HOWARD F. GOCHENOUR
13. Birthplace BALTO., MD.

MOTHER
14. Maiden Name VIRGINIA I. SCHAFER
15. Birthplace BALTO., MD.

16 (a) Informant HOWARD F. GOCHENOUR
(b) Address 1002 S. CONKLING ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-18-48 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEM.
Location 7225 EASTERN AVE.

18 (a) Funeral director Charles L. Seiler
(b) Address 901 S. CONKLING ST.

AUG 19 1948 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 15 1948 at 8.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 1941 to AUG. 15 1948, and that I last saw h/m alive on AUG. 14 1948.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGES	4 HRS
Due to EPILEPSY	9 YRS.
Due to CONGENITAL BRAIN INJURIES	9 YRS.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 124 S. HIGHLAND AVE. Date signed AUG. 16

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

65922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 65922

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 Elsinor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Napoleon B. Warner

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	None	male	white	single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3/2/1869

8. AGE: Years	Months	Days	If less than one day
79	5	14	hr. min.

9. Birthplace Loudon Co. Va. (Town, county, and state)
10. Usual Occupation Retired-
11. Industry or business Farming

FATHER
12. Name Gabrial V. Warner
13. Birthplace Loudon Co. Va.

MOTHER
14. Maiden Name Elizabeth Stocks
15 Birthplace Loudon Co. Va.

16 (a) Informant Mrs. Eliz. Nicholson
(b) Address 2213 Elsinor Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/18/48 (month) (day) (year)
(c) Cemetery ~~xxxxxxx~~ Lakeview Cem.
Location Hamilton, Va.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 AUG 17 1948 (Date rec'd by registrar) Washington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1948 at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1948 to 8/16 1948, and that I last saw him alive on 8/16 1948.

Immediate cause of death — Duration
cardiac failure
Due to chronic nephritis
Due to uremia
Other Conditions arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature D Shechler M.D.
Address Bon Secours Hosp Date signed 8/16/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G65923

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Virginia Esterley

5 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-7451

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Richard E. Esterley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9 1879

8. AGE: Years 49 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Frederick Md. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name William H. Hargett
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Clarendora E. Long
15. Birthplace Jefferson Md.

16 (a) Informant Esther R. Hargett
(b) Address 2304 W Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director Frederick R. Cole
(b) Address 2304 W. Lombard St.

AUG 17 1948 (Date rec'd by Registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1948 at 9:35 M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 7 1948, to Aug. 14 1948, and that I last saw h[illegible] alive on Aug. 14 1948.

Immediate cause of death Chronic Lymphoid Leukemia — Duration 5 years.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel L. Silverstein
Address West Baltimore Hosp. Date signed 8/17/48

VS 150

X

665924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. 665924

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 N. Durham St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Pauline Smetana

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank Anthony
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Oct. 2, 1904

8. AGE: Years	Months	Days	If less than one day
43	10	13	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob F. Ihle
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Kame[illegible]
15. Birthplace Germany

16 (a) Informant Frank Smetana
(b) Address 1617 N. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19 1948 (month) (day) (year)
(c) Cemetery Baltimore Lawn Location E. North Ave. Ext

18 (a) Funeral director Leo G. Cook
(b) Address 1201-03 N. Patterson Park Ave

19 (a) Filed AUG 19 1948 (b) Received by [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1948 at 11:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1948 to 8-15 1948, and that I last saw her alive on 8-15 1948

Immediate cause of death: Cardiac Failure — Duration:
Due to Rheumatic Heart Disease
Due to Rheumatic Fever — 35 yrs.

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Rheumatic Heart Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature J. Joseph Krajci M. D.
Address 1400 N. Caroline St Date signed 8-16-48

G65925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87E

G65925 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 N. Madeira, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Elmer Leonard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Louise Leonard
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 16 - 1900

8. AGE: Years	Months	Days	If less than one day
48	2-1	0 29	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Hucksters

FATHER 12. Name Winfield S. Leonard
13. Birthplace ?

MOTHER 14. Maiden Name Elizabeth
15. Birthplace ?

16 (a) Informant Winfield S Leonard
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1948 (month) (day) (year)
(c) Cemetery or crematory Oakland
Location Balto Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) Filed (date received by registrar) (b) Registrar Constance for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 15 - 1948 at 12 5-5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14- 1948 to 8-15- 1948. and that I last saw him alive on 8-15- 1948.

Immediate cause of death: Respiratory Failure — Duration: 0
Due to: Medullary herniation. — 0
Due to: Cerebro Vascular accident — 1½ d
Other Conditions: Dissection of Aorta — Late.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Evan Calkins M. D.
Address JOHNS HOPKINS HOSPITAL Date signed Aug 15

VS 150

065926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 461

Registered No. 065926

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22nd & CALVERT STREETS
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 ROLAND AVENUE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

2 (a) **FULL NAME** MRS. HERMAN L. PIEL (DORA M.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: HERMAN L. PIEL

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) APRIL 24 1878

8. AGE: Years 70 | Months 3 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation: NONE

11. Industry or business

PAYMENT
12. Name JOHN HENRY STUTT
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name MARY BUTCHER
15. Birthplace GERMANY

16 (a) Informant Herman D. Piel
(b) Address 208 Ridgewood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Brooklandtown, Balto Co. Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1960 Eastern Place, Balto 18

19 (a) AUG 17 1948 (Date rec'd by registrar) (b) Filed Aug 18 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15-48 1948, at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14-48 1948, to 8-15-48 1948 and that I last saw HER alive on 8-15-48 1948.

Immediate cause of death	Duration
GENERALIZED PERITONITIS	
Due to PERFORATION OF RECTUM	
Due to CARCINOMA OF RECTUM	
Other Conditions CARDIO VASCULAR HEART DISEASE (Include pregnancy within 3 months of death)	

Date of operation 8-14-48

Major findings of operation: GEN'L PERITONITIS PELVIC ABSCESS, PERFORATION OF RECTUM

or Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles H. Watts, Jr. M. D.
Address Union Memorial Hospital Date signed Aug 15, 1948

VS (50)

G65927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

✓ G65927 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2923 Baker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 6
(d) Street No. 2923 Baker St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Little

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NO

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ella Rose Little
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 26, 1861

8. AGE: Years 87 | Months 0 | Days 21 | If less than one day hr. min.

9. Birthplace York, Penn. (Town, county, and state)
10. Usual Occupation Funeral Director
11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Margaret E. ?
15. Birthplace Westmoreland CO. Va.

16 (a) Informant George A. Little
(b) Address 2923 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19, 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director John T. Stansbury
(b) Address 2700 Edmondson Ave.

19 AUG 17 1948 Filed by Registrar [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 19 48 at 8.1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1946 to Aug 16 1948 and that I last saw him alive on Aug 16 1948

Immediate cause of death
Ch. Myocarditis
Due to
Ch. Interstitial nephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
1948
1940

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1663 W. North Ave Date signed 8-17-48

VS 150

X

G65928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

Registered No. G65928

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold F. BABCOCK

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 012-07-9848

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1891

8. AGE: Years 57 | Months 5 | Days 15 | If less than one day: hr. min.

9. Birthplace Westerly, R.I.
(Town, county, and state)

10. Usual Occupation Claim Examiner

11. Industry or business Insurance

FATHER
12. Name Frederick Palmer Babcock
13. Birthplace Westerly R.I.

MOTHER
14. Maiden Name Ann Eliz. Chapman
15. Birthplace Westerly R.I.

16 (a) Informant: Avery Funeral Home
(b) Address Westerly R.I.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8/17/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Md.

19 (a) AUG 17 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1948, at M

21. I certify that I took charge of the remains described above, held an Inspection and Exam. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchial asthma

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner
Date signed 8/16/48

VS 151

G65929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

36

Registered No. G65929

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Home 3906 Gelston Drive
(c) Hospital or institution:
Lylenbam Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3906 Gelston Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David A. Manger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/22/35

8. AGE: Years	Months	Days	If less than one day
14	8	24	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sylvan A. Manger
13. Birthplace Baltimore

MOTHER
14. Maiden Name Thelma Hoffman
15. Birthplace Baltimore

16 (a) Informant Father
(b) Address 3906 Gelston Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18 '48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive
Location Randalstown Md

18 (a) Funeral director Harry H. Witzke
(b) Address 401 Edmondson Ave

19 (a) (Signature or initials of registrar) (b) Huntington Williams, M.D. Registrar
Aug 17 1948

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15 1948, at 5:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1948, to 8/15 1948, and that I last saw him alive on 8/15 1948.

Immediate cause of death Poliomyelitis — Duration 5 days of illness

Due to Bulbar Paralysis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene D. Geldstein M. D.
Address Lylenbam Hospital Date signed 8/15

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65930 A1903 ✓ G65930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 802 N. Carrollton Ave
(c) Hospital or institution: 16-1
(d) Length of stay in hospitl or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 N. Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Blanche Amos

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife [illegible]
6 (c) If alive, give age/ years

7. Birth date of deceased (mo., day, yr.) August 2, 1900,

8. AGE: Years	Months	Days	If less than one day
47	-	13	hr. min.

9. Birthplace Hartford County, Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Thomas H. Amos.
13. Birthplace Hartford, County Md.

MOTHER
14. Maiden Name Mary E. Jenkins,
15. Birthplace Hartford County, Md.

16 (a) Informant Miss Effie Amos
(b) Address 802 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16, 1947 (month) (day) (year)
(c) Cemetery or crematory Fair View
Location Hartford County, Md.

18 (a) Funeral director Mrs. Katie R. Wallace
(b) Address 322 N. Schroeder St. Baltimore, Md.

19 (a) AUG 17 1947 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Aug, 1947, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage
Spontaneous
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home or farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Beyer M.D.
Medical Examiner.
Date signed 8-17-47

VS 151

G65931 ✓ G65931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Dr. & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 754 Vine St.,
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ellis Dent

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: Ellis Dent
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Dec 8, 1887.
8. AGE: Years 60 | Months 8 | Days 6 | If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business:

FATHER
12. Name: James E. Dent
13. Birthplace: Md.

MOTHER
14. Maiden Name: Patricia Blair
15. Birthplace: Md.

16 (a) Informant: Records
(b) Address: U. S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19, 1948. (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location:

18 (a) Funeral director: Mrs. Katie R. Williams
(b) Address: 322 N. Schroeder St.

19 (a) AUG 17 1948 (Date rec'd by registrar) (b) Registrar: Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 48 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 19 48 to Aug 14 19 48, and that I last saw him alive on Aug 14 19 48.

	Duration
Immediate cause of death: Cirrhosis of liver with ascites, esophageal varices, gynecomastia	15 yrs
Intestinal obstruction, (ileum), due to adhesions	
Due to:	
Other Conditions: Inguinal hernia, left	
Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation: none
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Andrew J. McQueeney M. D.
Address: Marine Hospital Date signed: 8/15/48

VS 150

G65932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

V G65932 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St + Linden Ave 12
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2130 N Howard St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Pink Harris.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: N | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4 1904

8. AGE: Years 43 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Kentucky. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name William Harris.
13. Birthplace Kentucky

MOTHER 14. Maiden Name Anna Waters
15. Birthplace Ohio

16 (a) Informant Elliott Adkins.
(b) Address 2130 N. Howard St.

17 (a) Burial (Buried, cremation, or removal) (b) Date thereof August 19 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Ambrose.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St. Huntington Williams Mgr.

19 (a) AUG 17 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1948 at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/13 1948 to 8/14 1948, and that I last saw h[illegible] alive on 8/13 1948.

Immediate cause of death Cardio-respiratory failure — Duration ? 10 years

Due to Hypertension Cardiovascular disease — Duration 10 yrs

Due to Chronic nephritis — Duration 10 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles J. Hagen
Address Maryland General Hospital Date signed 8/14/48

VS 150

X

G65933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. G65933

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 633 George St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 George St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harriett Harris

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10 1874

8. AGE: Years 70 | Months aug | Days 106 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Joseph Salter
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Price
15. Birthplace Md.

16 (a) Informant Mrs. Mary Savage
(b) Address 633 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Fiddle St.

19 (c) AUG 17 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH August 16, 1948 at 5:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4 1948 to Aug. 16 1948, and that I last saw her alive on Aug. 15 1948

Immediate cause of death
Cerebral Hemorrhage
Due to Hypertensive Cardio-Vas. Dis.
Due to

Duration
4 days

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. McDonald M. D.
Address 844 N. Carey St. Balto. Date signed 8/17/48

VS 150

Please write plainly, with pen or indelible pencil. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

65934 231766

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. G65934

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 E. Eager 21 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Clapp. (Lula E. Clapp).

3 (b) If veteran, name war

3 (c) Social Security Account No. 224-14-4767

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm. E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-5-99

8. AGE: Years 48 | Months 8 | Days 11 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Nurse (Mothers Aide)

FATHER 12. Name Milton Morrison

13. Birthplace N. C.

MOTHER 14. Maiden Name Millie Leach

15. Birthplace N. C.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location

18 (a) Funeral director Robert F. Cowie

(b) Address 6716 W. Cardine St.

19 AUG 17 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1948 at 11:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1948 to Aug. 16 1948 and that I last saw her alive on Aug 16 1948

Immediate cause of death: Probable cerebral Thrombosis — Duration: hrs.

Due to: Hypertensive cardio-vascular dis. — years.

Due to:

Other Conditions: Gen. Arteriosclerosis — years.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral Arteriosclerosis + edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony V. Izzo. M. D.

Address JOHNS HOPKINS HOSPITAL Date signed 8-16-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G665935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G665935

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 Roland avenue
(c) Hospital or institution: Kirkleigh Villa
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 Kirkleigh Villa (If rural give location) 4301 Roland Ave.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN M. JOHNSTON

3 (b) If veteran, name war ----- | 3 (c) Social Security Account No. -----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 13, 1860

8. AGE: Years	Months	Days	If less than one day
88	5	2	hr min

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired School Teacher
11. Industry or business

FATHER
12. Name Joseph Johnson
13. Birthplace Hagerstown, Maryland

MOTHER
14. Maiden Name Caroline Costello
15. Birthplace Baltimore, Md.

16 (a) Informant Rev. Sr. M. Germaine
(b) Address 4301 Roland ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof AUG. 18-1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Chas. G. Graham's Son, Inc.
(b) Address 4 W. Mt. Royal Ave.

19 (a) AUG 17 [illegible] Washington-Baltimore
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1948, to Aug. 15 1948, and that I last saw her alive on Aug. 15 1948.

Immediate cause of death Hypertensive cardiovascular disease. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. D. Johnston M. D.
Address 701 N. Kenwood Ave. Date signed 9-16-48

VS 150

G65936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G65936

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 York Court (18) (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine E Vaughan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Eugene P Vaughan
6 (c) If alive, give age yrs.

7. Birth date of deceased (mo., day, yr) JAN 29-1861

8. AGE: Years 87 | Months 6 | Days 17 | If less than one day: hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name MAHER
13. Birthplace Ireland

MOTHER — 14. Maiden Name CATHERINE WARD
15. Birthplace IRELAND

16 (a) Informant Mrs. William I Welsh
(b) Address 12 York Court

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG 19-1948 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas J. Evans & Son Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) AUG 17 1948 (b) Registered by Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1948 at 11:A M

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 6 1948 to Aug 16, 1948. and that I last saw her alive on 8-16-1948.

Immediate cause of death Acute Cardiac Failure — Duration

Due to Old age, cachexia

Due to ~~Uremia~~ Phlebothrombosis

Other Conditions Fract. Duchism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 6-9-48 at ? M
(c) Where did injury occur? 12 York Co. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify) While at work? no
(e) Means of injury slipped + fell to floor

23. Signature C. D. Thomas, M. D.
Address Mercy Hosp. Date signed 8-14-48
~~Thomas J. Timmins~~ M. D.
1009

BC-48-16905

G65937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G65937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Berry St Balt (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/6/48

8. AGE: Years 0 | Months 0 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Charles R. Jenkins
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Jane Judsell
15. Birthplace Baltimore

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-48 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore

18 (a) Funeral director George B. Fuller
(b) Address Undertaker Fayette St.

19 (a) AUG 17 1948 (Date received by registrar) Huntington Williams Md. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15/48 19 at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 1948 to 8/15 1948 and that I last saw him alive on 8/15 19 48

Immediate cause of death Resp. failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature Joseph L. Gourley M.D.
Address Mercy Hosp. Date signed 8/15/48

VS 150

G65938 ✓ G65938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 101

2C- 6904-36

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 N. Monastary Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Katherine~~ KATHLEEN Rose

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1947

8. AGE: Years	Months	Days	If less than one day
	10	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name	John A. Rose
FATHER — 13. Birthplace	Philadelphia
MOTHER — 14. Maiden Name	Teresa Wilson
MOTHER — 15. Birthplace	Baltimore

16 (a) Informant Mr. John A. Rose
(b) Address 107 N. Monastary Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Fahey
(b) Address Shelton Bldg. Fayette St.

19 (a) (Date received) AUG 17 1948 Towson, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1948, at 9.15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Pulmonary Edema
Due to Acute Dilatation of Heart
Other Conditions Mesenteric Adenitis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed August 16, 1948

VS 151

95 C

665939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

✓ 665939 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Eastern Ave
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 Md. Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Charlotte Belle Fort

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: (Single)
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): July 28 1870
8. AGE: Years 78 | Months 0 | Days 19 | If less than one day: hr. min.
9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: music teacher
11. Industry or business: music
FATHER 12. Name: Leander Fort
13. Birthplace: Balto Md
MOTHER 14. Maiden Name: Ella Curtis
15. Birthplace: Balto Md
16 (a) Informant: Mrs W. L. Blanck (niece)
(b) Address: 2330 N. Calvert St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-48 (month) (day) (year)
(c) Cemetery or crematory: Greenmt
Location: Balto. Md.
18 (a) Funeral director: Sherwood Morgan
(b) Address: 108 W Monk Ave
19 (a) AUG 17 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1948 at 2 P M

21. I certify that I took charge of the remains described above, held an Inspection & Inq. Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions: Fracture of right hip

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 7-24-48 at ? M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: Slipped and fell to floor

23. Signature [signature] M.D. Medical Examiner
Date signed 8-17-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G65940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65940

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town ? (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Hammonds Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosalie SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1924

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School

AUG 16 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 AUG 17 1948 (Date rec'd by registrar) (Signature of Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1948, at 9 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Lobar pneumonia of both lungs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury,

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 8/9/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G65941 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 939 Lemmon St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 939 Lemmon St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Effie B. Applin

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24th 1889

8. AGE: Years 58 | Months 9 | Days 22 | If less than one day: hr. min.

9. Birthplace Harrisburg Va. (Town, county, and state)

10. Usual Occupation House work
11. Industry or business at Home

FATHER
12. Name John Goodman
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Flemming
15. Birthplace Va.

16 (a) Informant Mr Edward Applin
(b) Address 939 Lemmon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem Pk
Location Washington Blvd

18 (a) Funeral director John J. Govan & Son
(b) Address 901-03 Hollins St.

19 (a) AUG 18 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15th 1948, at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1948 to Aug 15 1948, and that I last saw her alive on Aug 5 1948.

Immediate cause of death: Acute Coronary Occlusion — Duration: 4 hours
Due to: coronary artery disease — 1 year
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan Rawlin
Address 206 S. Gilmor St. Date signed 8-16-48 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G65942

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2315 Mc Culloh St
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 Mc Culloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Lee

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	c	Widowed

6 (b) Name of husband or wife Charlotte Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10, 1868

8. AGE: Years	Months	Days	If less than one day
79	8	4	hr. min.

9. Birthplace md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name James W. Lee
13. Birthplace md

MOTHER
14. Maiden Name Lucy Woodland
15. Birthplace md

16 (a) Informant Lucy Lenkins
(b) Address 2315 Mc Culloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George E. Kelson
(b) Address 1203 Presstman St

19 AUG 18 1948 (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1948, at 5 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1948 to Aug 14 1948, and that I last saw him alive on Aug 13 1948.

Immediate cause of death
carcinoma of the prostate — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. H. Puttermann

Address 2324 Reisterstown Rd Date signed 8/17/48 (M. D.)

VS 150

5943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G65943

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2741 Mura Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Kuhn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1875

8. AGE: Years 73 | Months 1 | Days - | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Robert R. Kuhn
13. Birthplace Germany

MOTHER
14. Maiden Name Olivia Ballinger
15. Birthplace Washington D.C.

16 (a) Informant Frank Kuhn
(b) Address 2741 Mura Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1637 Broadway (Funeral Home) Washington Blvd

19 AUG 18 1948 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1948 at 7.05 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/16 1948 to 8/16 1948 and that I last saw h alive on 8/16 1948.

Immediate cause of death Cardiac failure - Coronary Sclerosis

Due to Arteriosclerotic Heart Dis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None at time

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D W Hunter M.D.
Address Church Home Date signed 8/16/48

VS 152

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Funeral Directors, with undertaking law, correct age is especially important.

G65944

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. G65944

CERTIFICATE OF DEATH

17 DC

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen'l Hosp 274
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3803 Parkside Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Leo McQuaid Jr

3 (b) If veteran, name war: 2 nd

3 (c) Social Security Account No. 217-20-3758

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19-1926

8. AGE: Years: 22 | Months: 5 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Vincent Leo McQuaid Sr
13. Birthplace: Balto

MOTHER
14. Maiden Name: Mildred Ellicott
15. Birthplace: Balto

16 (a) Informant: Mr Vincent J. McQuaid
(b) Address: 3803 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 19-48 (mo., day, year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balto

18 (a) Funeral director: J. A. Henderson
(b) Address: 3009 Pennsylvania ave

19 (a) AUG 18 1948 (Date rec'd by registrar) (b) Huntington W. Virginia, Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Aug 1948 at 5 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Crushed Chest
Rupture of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 15 Aug at 4:15 A.M.
(b) Where did injury occur? Ft. Smallwood Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger Auto

23. Signature: Frank Kemp M.D.
Medical Examiner
Date signed 15 Aug 48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

065945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 065945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3126 Clifmont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-4244

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Stella Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 55 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Newport (Town, county, and state)

10. Usual Occupation machinist

11. Industry or business

FATHER 12. Name Leon Kosacinski
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Stella Smith
(b) Address 3126 Clifmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jos. F. Hess & Son
(b) Address 3001 Kentucky Ave

AUG 18 1948 (Date rec'd by Registrar) Curtis Bay Md

ADA VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15 1948, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1948 to 8-15 1948 and that I last saw him alive on 8-15 1948.

Immediate cause of death: Coronary occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary occlusion

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Wm. Power, Jr. M. D.

Address Mercy Hosp. Date signed 8-15-48

X

65946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

✓ G65946 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 N. Pulaski St.
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIAN MITTNACHT

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~xxxxx~~ Harry Mittnacht
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1907

8. AGE: Years 41 | Months 3 | Days 10 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Calvin Oler
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catherine Kuhlmer
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Virginia Sebold
(b) Address 622 S. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore National
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) AUG 18 1948 (Date received by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15, 1948 at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1948 to Aug 15 1948
and that I last saw him alive on Aug 15 1948.

Immediate cause of death: Acute myocarditis — Duration: 1 wk

Due to

Due to

Other Conditions: Cirrhosis of Liver — unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Mittnacht

Address 1921 Whitelock Date signed 8/17/48

93a

G65947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49

Registered No. G665947

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 Wilkens Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19+
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Wilkens Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Lillie May Miller

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Peter J. Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 16, 1872

8. AGE: Years 75 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15 Birthplace unknown

16 (a) Informant EARL H. MILLER
(b) Address 1819 WILKENS AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto-City

18 (a) Funeral director Mrs. John W. Feikel & Son
(b) Address 5311 Edmondson Ave

AUG 18 1946 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1948, at 11.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 9, 1945 to Aug. 16 1948, and that I last saw her alive on Aug. 16, 1948.

Immediate cause of death: Cardiac Failure — Duration

Due to Carcinoma of the vulva

Due to

Other Conditions Secondary anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gaged & Kupp M. D.

Address 3030 Edmondson Ave. Date signed 8/17/48

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G665948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G665948 Registered No. 1382

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 Sharp St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 613 Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sylvester Lewis

3 (b) If veteran, name war 0

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Lucy Lewis

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 55 | Months | Days | If less than one day hr min

9. Birthplace Petersburg Va (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name Sylvester Lewis
13. Birthplace Va

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Lucy Lewis
(b) Address 613 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto. Md

18 (a) Funeral director Isaiah L Crowder
(b) Address 108 W Monument St

AUG 18 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10 1948 to 8-13 1948, and that I last saw him alive on 8-13 1948.

Immediate cause of death Tb-G.U. + Chronic Endocarditis — Duration

Due to ✓

Due to ✓

Other Conditions ✓

(Include pregnancy within 3 months of death)

Date of operation ✓

Major findings of operation: ✓

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James C Capers, M. D.
Address 1016 E. Sharp St Date signed 8-17-48

VS 150

65949 GM. 121972

BALTIMORE CITY HEALTH DEPARTMENT AUG 18 1948 Registered No. 665949

CERTIFICATE OF DEATH 132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 N. Washington ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis William Ruth

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 215-05-7559

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Mary A. Ruth
6 (c) If alive, give age yeara

7. Birth date of deceased (mo., day, yr.) Sept. 17 1876

8. AGE: Years	Months	Days	If less than one day
71	10	29	hr. min.

9. Birthplace MD. (Balto) (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Ruth
13. Birthplace MD.

MOTHER
14. Maiden Name Margaret Richter
15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 AUG 18 1948 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8- 16- 1948 at 6.35P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8- 9- 1948 to 8- 16- 1948, and that I last saw him alive on 8-16- 1948.

Immediate cause of death Pulmonary tuberculosis — Duration yeara

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Gayle Cantor, M.D.
Address Baltimore City Hospitals Date signed 8/17/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. 66950

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 241 S. Calhoun St.
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 241 S. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Lloyd

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Albert Lloyd
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) July 2, 1897

8. AGE: Years	Months	Days	If less than one day
51	1	14	hr. min.

9. Birthplace Shippingsburg, Md.
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Charles Suter
13. Birthplace Shippingsburg, Md.

MOTHER
14. Maiden Name Sarah Unknown
15. Birthplace Shippingsburg, Md.

16 (a) Informant Albert Lloyd
(b) Address 241 S. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17, 1897 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Tesch & Cole
(b) Address 1200 W. Lombard St.

AUG 18 1948
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16th 1948 at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946 to Aug 16 1948, and that I last saw h[illegible] alive on Aug 16 1948.

Immediate cause of death	Duration
Acute myocardial failure	
Due to Adeno-carcinoma of cervix	2½ yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Donlan M. D.
Address 4201 Wilkens Ave Date signed 8/17/48

V S 150

G65951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G65951 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1537 Pennington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 Pennington St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John F Cafary
3 (b) If veteran, name of war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife Emma M Cafary
6 (c) If alive, give years
7. Birth date of deceased (mo., day, yr.) May 16 — 1867
8. AGE: Years 81 | Months 5 | Days 1 | If less than one day hr. min.
9. Birthplace Waterford Co Cork (Ireland)
10. Usual Occupation Retired
11. Industry or business B & O

FATHER
12. Name Joseph Cafary
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Cafary
15. Birthplace Ireland

16 (a) Informant Emma M Cafary
(b) Address 1537 Pennington St
17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof Aug 20-48 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location
18 (a) Funeral director Chas L Fowler
(b) Address 3427 Eastern Ave
1948 AUG 18 1948 (b) [illegible]
(Date rec'd by registrar)

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1948 at 1:30 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1948 to Aug 17 1948. and that I last saw h[illegible] alive on Aug 10 1948.

Immediate cause of death — Duration
Respiratory Failure
Due to Coronary Occlusion
Due to Arteriosclerotic Cardio-vascular Renal disease
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Sborofsky M. D.
Address 6011 N. Monroe St Date signed 8/17/48 M. D.

65952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65952

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1003 Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 Rutland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Johnson Pick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10 1883

8. AGE: Years	Months	Days	If less than one day
65	5	5	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Richard Gaines
13. Birthplace Va.

MOTHER
14. Maiden Name Lucretia
15. Birthplace St Michaels Md

16 (a) Informant Savannah Gaines
(b) Address 1003 Rutland Ave.

17 (a) Burial (b) Date thereof 8/19/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Pott A. Elliott & Son
(b) Address 1129 N. Eutaw St

19 AUG 18 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 48 at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1, 1948 to Aug 15, 1948 and that I last saw him alive on 19

Immediate cause of death	Duration
Congestive Hrt. Failure	3 wks
Due to Hypertension	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. McDaniel M. D.
Address 807 N. Caroline Date signed 8-17-48

VS 190

This certificate should be typewritten. Every item must be answered; if unknown, state so. Omissions will delay registration. Physicians: please write the causes of death clearly and legibly. Be sure that the age is correct as it is especially important.

65953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65953 Registered No. 5855

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fix correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 N. Bruce St
(c) Hospital or institution:

16 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 708 N. Bruce St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Ingram

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife John Ingram.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day: hr.	min.
66				

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Jessie Waters
FATHER 13. Birthplace Md

MOTHER 14. Maiden Name
MOTHER 15. Birthplace —

16 (a) Informant Samuel Waters
(b) Address 708 N. Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director George E. Kelson
(b) Address 1303 Pennsylvania Ave

19 AUG 19 1948 (Date received by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1948, at 8 39 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/27 1948 to 8/14 1948, and that I last saw h[illegible] alive on 8/14 1948.

Immediate cause of death Carcinoma
breast fracture

Due to Hypertension

Due to

Other Conditions Chronic ureteral
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carson A. Gullen /Blackwell/ M.D.
Address 601 N. Carlton Date signed 8/19/48

VS 150

939

65954 - 104215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 66954

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Loraley, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. No Street Number (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Hyde O'Conner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 8, 1881

8. AGE: Years 67 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Timothy J. O'Conner

FATHER 13. Birthplace Pa.

MOTHER 14. Maiden Name Elizabeth Gilbert

MOTHER 15. Birthplace Md.

16 (a) Informant Bs Co Hs Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-48 (month) (day) (year)

(c) Cemetery or crematory Mayr Cathedral

Location Old Frederick Rd

18 (a) Funeral director John G Moran

(b) Address 3000 Walbrook Ave

AUG 18 1948 (Date Received by Registrar) (b) Registrar

VS 15)

To be approved by Medical Examiner

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 1948, at 1.05 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2 1948 to Aug. 15 1948. and that I last saw him alive on Aug. 15 1948.

Immediate cause of death Acute pulmonary edema — Duration

Due to Acute cardiac failure

Due to

Other Conditions Luetic amyotrophic (wasting-wasting) 3rd, R. hip

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: Above (brain not yet received)

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident 6-12

(b) Date of occurrence 8-8-48 at M

(c) Where did injury occur? Baltimore (City or town) Md (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Balto. City Hosp (Specify type of place) while at work? Yes

(e) Means of injury Fell out of bed at hosp.

23. Signature [illegible] M.D.

Address Balto City Hosp Date signed 8-15-48

G65955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G65955

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun
(c) Hospital or institution: Franklin Sq. Hosp 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 da
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 Burgundy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Farren

3 (b) If veteran, name war ?

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife Ruth Farren
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Feb 21, 1902

8. AGE: Years	Months	Days	If less than one day
46	5	16	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Patrick Farren
13. Birthplace Pa.

MOTHER
14. Maiden Name Anna Bortman
15. Birthplace Pa.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19-1948 (Month, day, year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director Pickel & B. M. Walter
(b) Address 1100 Eutaw St.

AUG 18 1948 (Date received by registrar)

Signature [illegible]

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1948 at 5 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26 1948 to 8-16 1948, and that I last saw him alive on 8-16 1948.

Immediate cause of death	Duration
Hemorrhage from esophageal varices	
Due to Cirrhosis of Liver	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Cirrhosis of liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq Hosp. Date signed 8-17-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G65956

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore – 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 Sinclair Lane
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Andrew Knudsen (RICHARD ANDREW KNUDSEN)

3 (b) If veteran, name war No.

3 (c) Social Security Account No. 705-05-0070

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Marie Elizabeth Knudsen

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr) 10/17/96

8. AGE: Years 51 | Months 10 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Civil Engineer

11. Industry or business B & O. R.R. Engineering Dept.

FATHER
12. Name Andrew Knudsen
13. Birthplace Norway

MOTHER
14. Maiden Name Not Known
15. Birthplace GERMANY

16 (a) Informant Mrs. Marie Knudsen
(b) Address 2113 Sinclair Lane – 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19. '48 (month) (day) (year)

(c) Cemetery or crematory Most Holy Redeemer
Location Baltimore Maryland.

18 (a) Funeral director HENRY SNYDER & SONS, INC.
(b) Address North Ave & Broadway. Baltimore 13

19 (a) AUG 18 1948 (Registrar's number) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1948 2:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1948 to Aug 16 1948 and that I last saw him alive on Aug 16 1948

Immediate cause of death Hemorrhage
Subarachnoid

Duration 24 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roy E. Reeder Jr. M. D.
Address St. Joseph Hosp. Date signed Aug 16, 1948

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G65957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G65957

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 218 So. Payson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 So. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Doris E. Weaver

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Joseph R.
6 (c) If wife, give age years
7. Birth date of deceased (mo., day, yr.) Mar 26th 1923
8. AGE: Years 25 | Months 4 | Days 22 | If less than one day: hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name Anthony R. Seabott
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Josephine E. Boyle
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Josephine R. Seabott
(b) Address 218 S. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral Cem.
Location 4300 Old Frederick Road

18 (a) Funeral director George J. Logan & Son
(b) Address 701-03 W. Lanvale St.

19 AUG 18 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17th 1948 at 10.30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 17 1947, to Aug 17 1948, and that I last saw h[illegible] alive on Aug 16 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Pulmonary Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public [illegible]? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliott Seagrotta M. D.
Address 1729 W. Lanvale St. Date signed Aug 17 '48

VS 153

X

665958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 94a

Registered No. 665958

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 Andrea Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN PAWLICKI

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Mill hand

11. Industry or business Box Factory

FATHER
12. Name Michael Pawlicki
13. Birthplace Poland

MOTHER
14. Maiden name Wanda Emalewicz
15. Birthplace Poland

16 (a) Informant Frank Jazosinski
(b) Address [illegible] Chester

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19/48 (Month) (Day) (Year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address [illegible] Eastern Ave Baltimore, Md.

19 AUG 18 1948 (Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1948 at 2P M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl C. Rogers M.D. (Medical Examiner)
Date signed 8-17-48

X

Please write plainly, with pen and ink. Physicians: please write the causes of death clearly and legibly. Be sure to answer every question. Where information should be entirely supplied, the correct age is especially important.

5959 Homer D. Rich Homer DeWayne Rich

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G65959

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richard & Lombard
(c) Hospital or institution: Univ. Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4441 Newport Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Homer D. Rich

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-10-9051

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs. Homer D. Rich
Edith Bonner Rich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 24, 1895

8. AGE: Years	Months	Days	If less than one day
52	10	23	hr. min.

9. Birthplace Northfield, Vermont
(Town, county, and state)
10. Usual Occupation Administrative Supt.
11. Industry or business Balmar Corp.

FATHER
12. Name James Hollis Rich
13. Birthplace Vermont

MOTHER
14. Maiden Name Edith M. Ingalls
15. Birthplace Vermont

16 (a) Informant Mrs. Edith Bonner Rich
(b) Address 4441 Newport Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Mary's (Hampden)
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 AUG 18 1948 (Date received by Registrar) (b) Harrington Williamson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17 1948 at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1 1948 to 5-17 1948, and that I last saw h[illegible] alive on 5-12 1948

Immediate cause of death [redacted] pulmonary embolism — Duration

Due to coronary thrombosis

Due to pulmonary edema

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Howard S. Hall M. D.
Address Univ. Hosp. Date signed 8-17-48

VS 150

Please write plainly. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. G65960

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3106 Tioga Parkway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Tioga Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY PRAGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 1900

8. AGE: Years: 48 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation: Shoe Maker
11. Industry or business:

FATHER
12. Name: Rubin Prager
13. Birthplace: Russia

MOTHER
14. Maiden Name: Matilda ?
15 Birthplace: Russia

16 (a) Informant: Mr. Robert Prager
(b) Address: 3106 Tioga Parkway

17 (a) Burial (b) Date thereof 8-19-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Adas Israel Cem.
Location: German Hill Road
Sol. Levinson & Bros.

18 (a) Funeral director
(b) Address: 1124-26 W. North Avenue

19 (a) AUG 18 1948 (b) Huntington-Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1948, at 7A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1948 to 8/18 1948, and that I last saw h[illegible] alive on 4/28 1948.

Immediate cause of death, Cerebral Hemorrhage

Due to Arteriosclerosis

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Daniel J. Schwartz
Address 2320 Eutaw Pl. Date signed 8/18/48 M.D.

VS 150

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

65961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 65961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 855 W. Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 855 W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Hallis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1913

8. AGE: Years	Months	Days	If less than one day
35	3	16	hr. min.

9. Birthplace Henderson, N.C. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Benjamin Hallis.
13. Birthplace Henderson, N.C.

MOTHER
14. Maiden Name Lucinda Bowman
15 Birthplace Henderson, N.C.

16 (a) Informant William Brooks
(b) Address 855 W. Franklin

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Aug. 18, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Henderson, N.C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) AUG 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17, 1948 at 4:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9, 1948 to Aug 17, 1948 and that I last saw him alive on Aug 17, 1948.

Immediate cause of death — Duration
Pulmonary Tuberculosis — 2 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature McDonald Bando M. D.
Address 2445 W. Hall Ave. Date signed 8-18-48

VS 150

665962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 665962

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2313 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID CARROLL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Catherine Carroll

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 60 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Carroll Co Md (Town, county, and state)

10. Usual Occupation Butler

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Catherine Carroll
(b) Address 2313 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (mo.) (day) (yr.)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna Ave

19 (a) AUG 18 1948 (Date rec'd by registrar) (c) Huntington Williams Reg.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1948 at 10.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to Generalized A. S. C. V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. (Medical Examiner)
Date signed August 16, 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65963

166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals 2 b 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unidentified Colored Man Lawrence William Unknown

3 (b) If veteran, name war

3 (c) Social Security Account No. Unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	Unknown

6 (b) Name of husband or wife "

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
45?				

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation "

11. Industry or business "

FATHER
12. Name "
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant "
(b) Address "

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/48 (month) (day) (year)
(c) Cemetery or crematory Potters Field Home
Location Texas and

18 (a) Funeral director J. B. Connelly.
(b) Address 418 Eastern Ave.

19 AUG 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1948, at 6:19 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of spine and abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-20-48 at 5:00 P M.
(b) Where did injury occur? North Point Rd. (Bay View Park - P. R. R.)
(c) Did injury occur at home, on farm, industrial place, or public place? industrial place While at work? no
(d) Means of injury Gun shot

23. Signature Earl L. Boyer M.D.
Medical Examiner.
Date signed July 20, 1948

G65964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G65964

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 S. Bethel St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Russia

3 (a) FULL NAME Alexander Stopczuk (Ostopczuk)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Helen Stopczuk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 4, 1893

8. AGE: Years 55 Months Days If less than one day hr min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Stopczuk
13. Birthplace Russia

MOTHER
14. Maiden Name Joan?
15. Birthplace Russia

16 (a) Informant Records-Balto. City Hospital
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Church
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) AUG 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1948, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15 1948 to 8-16 1948 and that I last saw him alive on 8-16 1948

Immediate cause of death: Carcinoma of stomach 1 yr. — Duration

Due to peritoneal carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. F. Nelson

Address Date signed 8/17/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C65965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C65965

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4204 Woodstock Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4204 Woodstock Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSE GAY PRICE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Mahlon S. Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1876

8. AGE: Years	Months	Days	If less than one day
71	11	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name James Leetch
13. Birthplace Ireland

MOTHER
14. Maiden Name Lina Mulkins
15. Birthplace New York

16 (a) Informant Mr. Vernon Price
(b) Address 4204 Woodstock Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-48 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) AUG 18 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/28 1947 to 8/17 1948 and that I last saw h[illegible] alive on 8/17 1948.

Immediate cause of death Cardiac pulmonary failure — Duration 25½ mos.
Due to Coronary arterio sclerosis
Due to arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanowski, M.D.
Address 1127 St Paul St. Date signed 8/19/48

VS 150

65966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

Register No. 65966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 PARK AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 PARK AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLOTTE A. CRAWFORD

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband ~~or wife~~ late JOHN D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 29, 1857

8. AGE: Years	Months	Days	If less than one day
91	0	17	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name — YENGLING
13. Birthplace —

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant MRS MILDRED BALLAND
(b) Address 1501 BOLTON ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 19, 1948 (month) (day) (year)
(c) Cemetery or crematory ST JOHN CATHOLIC
Location WESTMINSTER, MD

18 (a) Funeral director Hann & Withe
(b) Address 410 [illegible] Ave Washington, Maryland

19 (a) AUG 18 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 16 1948 at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 9 1948 to AUG. 16 1948, and that I last saw her alive on AUG. 16 1948.

Immediate cause of death Uremia — Duration 2 days
Due to Hypertension Cardio-Vascular Renal — 4 yrs.
Due to Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Taylor M. D.
Address 3902 Greenmount Ave Date signed Aug 17, 48

VS 190

G65967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V126

Registered No. G65967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 - 15 +
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1932 Griffin ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mrs Mary C Butts

3 (b) If veteran, name war

3 (c) Social Security Account No 236-14-7089

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Charles S. Butts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 1, 1884

8. AGE: Years 63 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state) Glass

10. Usual Occupation Miller - Carp - Joiner & Factory

11. Industry or business

FATHER 12. Name John L Nogle

13. Birthplace Va

MOTHER 14. Maiden Name Mary Blaser

15. Birthplace Va.

16 (a) Informant Eliza Smaltz

(b) Address 1932 Griffin Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/20/48 (month) (day) (year)

(c) Cemetery or crematory Bethel

Location Sleepy Creek W. Va.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) AUG 19 1948 (Date rec'd by registrar) (b) Huntington Williams, Mgr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1948 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 1948 to 8-18 1948 and that I last saw h er alive on 8-18 1948.

Immediate cause of death Cardiac failure

Due to myocarditis

Due to Generalized toxemia from gangrenous cystitis

Other Conditions Perforation + walled off abscess

(Include pregnancy within three months of death)

Date of operation 8/16/48

Major findings of operation: Gangrene cholecystitis & cholelithiasis

of autopsy: See above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. J. Verska Jr MD

Address St. Agnes Hospital Date signed 8/18/48

V2 30

65968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65968

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address No. 526 - Orchard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give location)
(d) Street No. 526 - Orchard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Baby) Rufus Gibson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 13 1948

8. AGE: Years | Months | Days 5 | If less than one day min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER 12. Name Frazier Gibson
13. Birthplace S.C.

MOTHER 14. Maiden Name Lucilla ?
15. Birthplace S.C.

16 (a) Informant Frazier Gibson
(b) Address 526 Orchard St.

17 (a) Burial Denial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary.
Location

18 (a) Funeral director A. Halsted
(b) Address 918 - Druid Hill Ave

19 AUG 19 1948 (Date rec'd by registrar) (b) Washington Undertaking Co. Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1948 at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1948 to Aug 18 1948. and that I last saw him alive on Aug 18 1948.

Immediate cause of death Obstructive jaundice — Duration 2 days.

Due to Congenital

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Garland Pinell M.D.
Address 902 E. Franklin Date signed 8-18-48

VS 150

IDA WING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (1937)

Registered No. G65969

G65969

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address or Hospital or institution: 751-W. Franklin St University Hosp. D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 751-W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Wing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Thompson
13. Birthplace Md.

MOTHER 14. Maiden Name Emma ?
15. Birthplace Md.

16 (a) Informant Chas Thompson
(b) Address 910- Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)
(c) Cemetery or crematory Prot. Calvary.
Location

18 (a) Funeral director E. Halstead
(b) Address 918- Druid Hill Ave

19 (a) AUG 19 1948 (Date rec'd by registrar) (b) Huntington Woods, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Aug 48, 19 , at 1 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteria-Sclerotic R.D.

Due to Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 15 Aug 48

VS 151

G65970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65970

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if available. Physicians: please write the causes of death clearly and legibly. If correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard St. and Poppleton Ave.
(c) Hospital or institution: Mercy Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 828 Whitmore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Lee Moog
3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Albert Lee Moog
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 28, 1890
8. AGE: Years 57 | Months 9 | Days 20 | If less than one day: hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name William G. Towers Sr.
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name MARY A. FLINT
15. Birthplace Virginia

16 (a) Informant Mr. Albert L. Moog
(b) Address 828 Whitmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Cem.
Location Balto. Md.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 AUG 19 1948 (Date rec'd by city or county registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18th 1948, at 12:01 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13th 1948. to Aug. 18th 1948. and that I last saw her alive on Aug. 18 1948.

	Duration
Immediate cause of death Cerebral embolism	
Due to: Rheumatic Heart Disease	
Contributing hypertrophy & dilitation	
Due to Mitral Stenosis & Auricular Fibrosis	
Bilateral pleural effusion	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Mitral stenosis auricular fibrosis Cardiac hypertrophy & dilitation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Katherine V. Kemp M. D.
Address Mercy Bal. Gen. Hosp. Date signed Aug. 19th 1948

VS 180

G65971

EB-01688

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 107

G65971
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals 28 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs. 7 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 Hillsdale Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Schaefer ELIZABETH R. SCHAEFER ✓

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jean Schaefer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1880

8. AGE: Years: 68 | Months: 1 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Pa. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: John Redington (Reddington)
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Susanna Schermer
15. Birthplace: Pa.

16 (a) Informant: Records, Baltimore City Hospitals
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/48 (month) (day) (year)
(c) Cemetery ~~or Crematory~~ Loudon
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS INC.
(b) Address: North & Pa. Aves. Balto. 17, Md.

19 (a) Rec'd by Reg'r Aug 19 1948 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18 1948, at 7:35 a M

21. I certify that death occurred on the date above stated, that I attended deceased from 1-19 1948 to 8-18 1948, and that I last saw her alive on 8-18 1948

Immediate cause of death: Bronchopneumonia, Lobar — Duration: 1 wk.

Due to

Due to

Other Conditions: Diverticulosis, with perforation into rectal [illegible]
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Mahoney
Address Balto City Hosp Date signed 18 Aug 48 (M.D.)

VS 193

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 150

G65972 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert St.

(c) Hospital or institution: Union Memorial Hospital 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 79 days

(e) Length of stay in Baltimore, (yrs., mos., or days) 43 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4404 Marble Hall Road, 18 (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Rebecca T. Newbraugh ANN REBECCA NEWBRAUGH

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ramsey C. Newbraugh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): January 6 1905

8. AGE: Years 43 | Months 7 | Days 10 | If less than one day: hr. min.

9. Birthplace: West Virginia Martinsburg (Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business

FATHER 12. Name: Charles E. Thompson

FATHER 13. Birthplace: West Virginia

MOTHER 14. Maiden Name: Grace A. Kershaw

MOTHER 15. Birthplace: West Virginia

16 (a) Informant: Husband

(b) Address: Same as deceased

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)

(c) Cemetery or crematory: Rosedale

Location: Martinsburg, W. Va.

18 (a) Funeral director: Wm. J. TICKNER & SONS INC.

(b) Address: North & Pa. Aves. Balto. 17, Md.

19 (a) AUG 19 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1948, at 4 58 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1948 to Aug. 16 1948, and that I last saw her alive on August 16 1948.

Immediate cause of death: generalized Carcinomatosis — Duration: 2 months

Due to: Carcinoma of breast bilateral — 2 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation May 6 1948

Major findings of operation: Carcinoma of breast

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. F. Cox 3rd

Address Union Memorial Hospital Date signed Aug 16 1948 M. D.

VS 150

G65973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65973 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W 40th St
(c) Hospital or institution: House for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs 3 mos 11 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto Co
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 West 40th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Mr. W. Irving Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed~~, or ~~divorced~~
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 24, 1864

8. AGE: Years	Months	Days	If less than one day
84	6	23	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER 12. Name John W. Davis
13. Birthplace Baltimore

MOTHER 14. Maiden Name Anna J. Fields
15. Birthplace St Mary's Co. Md

16 (a) Informant Frances M. Hazard
(b) Address House for Incurables

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore
Location North Ave at C-94

18 (a) Funeral director John O. Mitchell & Sons Co.
(b) Address 1900 Eutaw Place

19 (a) AUG 19 1948 (b) Huntington Williams M.D.
(Accepted by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1948 at 6.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1945 to 8/17 1948, and that I last saw him alive on 8/16 1948.

	Duration
Immediate cause of death: Cerebral Vascular Accident (Right)	3 Months
Due to: Essential Hypertension	6 years
Due to: Arteriosclerosis (General)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. Grafton Humphreys M. D.
Address 214 Medical Arts Bldg Date signed 8/17/48

VS 150

G65974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G65974

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3916 Second St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3916 Second St (If rural give location)
(e) Citizen of foreign country? — No (Yes or No)
If yes, name country —

3 (a) FULL NAME Laura Ellen Baldwin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George Raymond Baldwin 6 (c) If (live, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1895

8. AGE: Years	Months	Days	If less than one day
53	3	8	hr. min.

9. Birthplace Queens Co Virginia (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name William Garnett
13. Birthplace Virginia

MOTHER
14. Maiden Name Virginia ?
15. Birthplace Virginia

16 (a) Informant George R. Baldwin
(b) Address 3916 Second St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Ruckie Henry A. & Co.

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St

19 (a) AUG 19 1948 (Date received by registrar) (b) Tennington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17, 1948, at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 6 1948, to Aug. 17, 1948, and that I last saw h[illegible] alive on Aug 17 1948.

Immediate cause of death Circulatory insufficiency — Duration 6 months

Due to Generalized carcinoma

Due to Cancer of the stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation May 1948

Major findings of operation: Cancer of stomach, perforation of stomach

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Neuhauser M. D.
Address 936 Patapsco Ave. Date signed 8-18-48

665975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 B

Registered No. 665975

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 941 N. Duncan St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 941 N. Duncan St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balt Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Kardian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna Kardian

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) May 19-1883

8. AGE: Years 65 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation Grape Sharter

11. Industry or business Shipbuilding

FATHER
12. Name Frank Kardian
13. Birthplace Bohemia

MOTHER
14. Maiden Name Kat Brown
15. Birthplace Bohemia

16 (a) Informant Anna Kardian
(b) Address 941 N. Duncan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balt Md

18 (a) Funeral director Hamilton Boyce Hardesty
(b) Address 902 N Gilmor St

19 (a) AUG 19 1948 (Date rec'd by Registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Aug 17 1948, and that I last saw him alive on Aug 17 1948.

Immediate cause of death Carcinoma-Prostate
Bronho-pneumonia
Due to Arteriosclerosis-Generalized
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 3 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis F. Klimes M. D.
Address 2623 E. Monument St Date signed 8/18/48

VS 150

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65976

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95 B

Registered No. G65976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, 324 E. Biddle St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 34

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 321 E. Biddle St (If rural, give location)
(e) Citizen of foreign country? Unknown (Yes or No)
If yes, name country

3 (a) FULL NAME Constantino Procopio

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1895

8. AGE: Years	Months	Days	If less than one day
53	0	25	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation
11. Industry or business Real Estate

FATHER
12. Name ?
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant John Menzer
(b) Address Pheonix, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore

18 (a) Funeral director Rita Niedefeld
(b) Address 800 East Biddle St.

19 (a) AUG 19 1948 (Date received by Registrar) (b) Huntington, Indiana
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1948 at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 14 1948 to August 17 1948 and that I last saw h[illegible] alive on August 17 1948.

Immediate cause of death Cardiac Decompensation

Due to Rheumatic heart disease

Due to

Other Conditions Hydrothorax, enlargement of heart, CHF & lungs, liver

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James J. Morton, M.D.
Address 5106 Harford Rd Date signed 8/19/48

VS 150

G65977

G65977

OC-48-1332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Univ.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4 DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James L. MARINER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months 2 | Days | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Chas. Marinar
13. Birthplace Va

MOTHER
14. Maiden Name Helen Hightower
15. Birthplace Md.

16 (a) Informant Helen Mariner
(b) Address 1030 N. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 19 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co.

18 (a) Funeral director Mr. Robt. H. Elliott & Daughter
(b) Address 1129 N. Carlton St

19 (a) AUG 19 1948 (Date rec'd by registrar) (b) Huntington Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1948 at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Upper respiratory infection
Status thymico lymphaticus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner

Date signed 8/18/48

VS 181

G65978 #7163

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 157E

G65978 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ala. (b) County
(c) City or town Montgomery (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 N. Jackson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Truett (FRANCES TRUETT)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced —
6 (b) Name of husband or wife —
6 (c) If alive, give age / years
7. Birth date of deceased (mo., day, yr) 12-2-41
8. AGE: Years 6 Months 8 Days 16 If less than one day hr. min.
9. Birthplace Ala. - (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER 12. Name David Truett
13. Birthplace Ala.

MOTHER 14. Maiden Name Ruth Madden
15. Birthplace Ga.

16 (a) Informant Parents.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/48 (month) (day) (year)
(c) Cemetery or crematory Oakwood Cem.
Location Montgomery Alabama

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 AUG 19 1948 (Date received by Registrar) (b) Huntington for Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18, 1948 at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1948 to Aug. 18 1948 and that I last saw h[illegible] alive on Aug. 18 1948

Immediate cause of death CARDIAC FAILURE — Duration LIFE

Due to TETRALOGY OF FALLOT

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: SAME

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Richard C. Clay M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 8/18/48

THESE WRITINGS, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 15?

X

665979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

665979 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital 5-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Fernhill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIAN ROBINSON

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: White | 5. Color or race: Female | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Joseph T. Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1903

8. AGE: Years 44 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Philip Wachter
13. Birthplace: Md.

MOTHER
14. Maiden Name: Cardine Beck
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. John Moll (Sister)
(b) Address: 3333 Sussex Road, Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month) (day) (year)
(c) Cemetery or crematory: First Evangelical Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 AUG 19 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, at 1:45 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 8-18-48

VS 151

665980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 665980

170c

FILL WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George EMMETT BURCH

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Barbara

6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr): Jan. 27, 1897

8. AGE: Years 51 | Months 6 | Days 22 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business: U.S. Navy Yard

FATHER
12. Name: George Burch
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Jennie Smith
15. Birthplace: Maryland

16 (a) Informant: Mrs Barbara Burch
(b) Address: 1830 N. Castle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/21/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) AUG 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1948, at 3 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Drowning

Due to

Other Conditions (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-18-48 at Approx. 12:50 A. M.
(b) Where did injury occur? Clifton Lake, Clifton Park
(c) Did injury occur at home, on farm, industrial place, in public place? Public Was it at work? No
(d) Means of injury: Auto ran off road, ran through iron fence and plunged into Lake

23. Signature: George L. Merrill M.D. Medical Examiner.
Date signed 8/18/48

VS 151

C665981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ C665981 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 S Patterson Park
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 S Patterson Park
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Bednarz

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Wh | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Angeline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19 - 1895

8. AGE: Years 53 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Chicago Ill
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Andrew Bednarz
13. Birthplace Poland

MOTHER 14. Maiden Name Mary Kula
15. Birthplace Poland

16 (a) Informant Angeline Bednarz
(b) Address 416 S Patterson Pk.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20/48 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Bruce Gaszewski
(b) Address 1938 Eastern Ave

19 (c) AUG 19 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 1948, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1948 to Aug 17 1948, and that I last saw him alive on Aug. 17 1948.

Immediate cause of death
Coronary Thrombosis — Suddenly — Duration

Due to

Due to

Other Conditions

(Includes pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sigmund R. Nowak M.D.
Address 408 S. Patterson Park Date signed 8-17-48

VS 150

X

C65982

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164a

Registered No. C65982

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES CARROLL HALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1881

8. AGE: Years	Months	Days	If less than one day
67	1	10	hr. min.

9. Birthplace Baltimore County
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Beverly H. Hall
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Mary Jane Thompson
15. Birthplace Maryland

16 (a) Informant Miss Edna B. Hall
(b) Address 4701 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) AUG 19 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1948, at 1.40a.M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-19-48 at 12.45 a.M.
(b) Where did injury occur? Barn at rear of 4701 Harford Road
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury hanged self from rafter in barn

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed August 19, 1948

VS 151

G65983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G65983 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fallsway & Lombard Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1044 W. Franklin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan SANDERS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 11, 1916

8. AGE: Years	Months	Days	If less than one day
31	10	5	hr. min.

9. Birthplace Blackville, S.C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Elzie Sanders
13. Birthplace Blackville, S.C.

MOTHER
14. Maiden Name Janie Fuller
15. Birthplace Blackville, S.C.

16 (a) Informant Mabel Taylor
(b) Address 1044 W. Franklin Street

17 (a) Burial (b) Date thereof Augo 20 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. William
(b) Address 312 W. Lexington St. Baltimore Md.

19 (a) (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1948 at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☐, accident probably X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found: 8-16-48 1:50 P M.
(b) Where did injury occur? Found: Jones Falls--Fallsway & Lombard St.
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? No
(d) Means of injury Found drowned

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8/17/48

VS 151

G65984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

✓G65984 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 744 Waesche Ste
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 744 Waesche St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theodore Suffman.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Mald | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Estella Suffman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1891

8. AGE: Years 57 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Joseph Suffman.
13. Birthplace

MOTHER 14. Maiden Name
15 Birthplace

16 (a) Informant Estella Suffman.
(b) Address 744 Waesche St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1948, at 12.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1948 to 8/16 1948, and that I last saw h. alive on 8/15 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 Mo.

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William Causey
Address 23 George St. Date signed 8/16/48

VS 150

G65985

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

✓ G65985 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 North Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esline EVALINE OFFER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3 1947.

8. AGE: Years 1 | Months 16 4 | Days 14 | If less than one day hr. min.

9. Birthplace Churchton, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Herbert Offer.
13. Birthplace Churchton, Md.

MOTHER
14. Maiden Name Mary Williams.
15. Birthplace Ellicott City, Md.

16 (a) Informant: Mary Offer
(b) Address 113 N. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19, 1948. (month) (day) (year)
(c) Cemetery or crematory Int. Auburn
Location

18 (a) Funeral director Mrs. F. R. William.
(b) Address 322 N. Schroeder St.

AUG 19 1948 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, at 8.50 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to confination of Smoke.

Due to

Other Conditions Bilateral Bronchopneumonia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner. M.D.

Date signed August 18, 1948

G65986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65986
Registered No.

170c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 N. Castle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: LAURA MARIE FOARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Edwin M. Foard jr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1927

8. AGE: Years 21 | Months 3 | Days 6 | If less than one day: hr. min.

9. Birthplace: Wisconsin
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: William Bamlett
13. Birthplace: Illinois

MOTHER
14. Maiden Name: Ellen Lawless
15. Birthplace: Ireland

16 (a) Informant: Edwin M. Foard Jr.
(b) Address: 1826 N. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/1948 (month) (day) (year)

(c) Cemetery or crematory
Location: Beloit, Wisconsin.

18 (a) Funeral director: Flynn & Fleming
(b) Address: 1426 Light Street

19 (a) Date received by registrar AUG 19 1948 (b) [signature]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18, 1948, at 3 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, ~~accident~~ ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-18-48 at Approx. 12:50 A. M.
(b) Where did injury occur? Clifton Lake, Clifton Park
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Auto. missed road, ran through fence and plunged into Lake

23. Signature [signature] M.D.
Medical Examiner

Date signed 8-18-48

G65987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65987 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 N. Castle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Mary Frances Foard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1919

8. AGE: Years: 29 | Months: 4 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business: Clerk

FATHER
12. Name: E. Morris Foard
13. Birthplace: 1826 N. Castle St.

MOTHER
14. Maiden Name: Catherine P. Brown
15. Birthplace: Baltimore, Md.

16 (a) Informant: E. Morris Foard
(b) Address: 1826 N. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/1948 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: Flynn & Fleming
(b) Address: 1426 Light Street.

AUG 19 1948 (Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18, 1948, at 3:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-18-48 at Approx. 12:50 A.M.
(b) Where did injury occur? Clifton Lake, Clifton Pk
(c) Did injury occur at home, on farm, industrial place, in public place? Public (While at work) No
(d) Means of injury: Auto missed rd. ran through wire fence and plunged into lake.

23. Signature: M.D. (Medical Examiner)

Date signed 8-18-48

A 64 817
G65988
-36-48-0185

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

Registered No. G65988

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Middle River
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 36 S. Randolph Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kenneth Hoke

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-25-48

8. AGE: Years	Months	Days	If less than one day hr.	min.
0	7	23		

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Kenneth Hoke
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Ruden
15. Birthplace Md.

16 (a) Informant Husband
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)
(c) Cemetery or crematory Edmondson
Location Old Forest Lawn

18 (a) Funeral director Lilly & Zepp
(b) Address 410 E. Lafayette Ave

(a) (Date) 19 (b) (Local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1948 at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1948 to Aug 17 1948 and that I last saw him alive on Aug 17 1948

Immediate cause of death: Paroxysmal Dyspnea — Duration
Due to: Congenital Heart Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton McKenney M.D.
Address JOHNS HOPKINS HOSPITAL (Date signed)

G65989 BALTIMORE CITY HEALTH DEPARTMENT ✓ G65989
AB-119593 CERTIFICATE OF DEATH 12B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1847 Lorman St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Portia Delores Tilghman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr April 21- 1933

8. AGE: Years 15 | Months | Days | If less than one day hr. min. 23.15

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER 12. Name Edward Foster
13. Birthplace Va.

MOTHER 14. Maiden Name Ethel Tilghman
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 AUG 19 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16- 1948 at 2.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1948 to 8-16 1948, and that I last saw him alive on 8-16 1948

	Duration
Immediate cause of death For advanced bilateral pulmonary tuberculosis with extensive cavitation	6 months
Due to with tuberculous laryngitis	2 months
Due to	

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at (work)?
(Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M. D.
Address Baltimore City Hosp. Date signed 8-17-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G65990 Registered No. 13 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 252 N. PINE ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 252 N. Pine ST (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES R. SMITH

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex MALE

5. Color or race C

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-15-1879

8. AGE: Years 69 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Samuel K. Smith

FATHER 13. Birthplace Md

MOTHER 14. Maiden Name Adeline

MOTHER 15. Birthplace Md

16 (a) Informant Bertha Smith (wife)

(b) Address 651 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto. Md.

18 (a) Funeral director Chas. Harper

(b) Address 520-12 Carroll Lanes

19 (a) [illegible] (Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1948, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11 1948, to 8-16 1948, and that I last saw him alive on 8-16 1948.

Immediate cause of death: PULMONARY TUBERCULOSIS — Duration: UNKNOWN

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas W. Hunn M. D.

Address 1824 W Fayette St Date signed 8-17-48

VS 180

X

G65991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G65991

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins University 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) D. 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1165 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB WEVELO (JACOB NENDEL WEREBLOW)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name HARRY-
13. Birthplace RUSSIA

MOTHER 14. Maiden Name MIRIAM-
15. Birthplace RUSSIA

16 (a) Informant Mrs. Harry BLENNER, Cousin
(b) Address 270 HUNTINGTON ST, NEW HAVEN

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-48 (month) (day) (year)

(c) Cemetery or crematory Shalom Mt. Carmel
Location Mountain View Rd.

18 (a) Funeral director Jack Levine, Inc.
(b) Address 2100 (702 Eutaw Place) Huntington Wellington, Md.

19 AUG 19 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, at 8:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner M.D.
Date signed 8-17-48

VS 151

G65992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH M3D

Registered No. G65992

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5901 Eastern Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5812 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Passaro

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-14-8709

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife late Assunta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17 1890

8. AGE: Years	Months	Days	If less than one day
58	4		hr. min.

9. Birthplace Busco Italy (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Angelo Passaro
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Suriano
15. Birthplace Italy

16 (a) Informant Anna Ruley (Daughter)
(b) Address 5812 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 22/48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Rd. Balt. Md.

18 (a) Funeral director Frank Della Rose
(b) Address 322 S. High St.

19 (a) AUG 19 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17-48 19 , at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-Respiratory Failure

Due to Hypertensive Cardio-Vascular Disease

Other Conditions Coarctation of the Aorta

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John B. Maddux M.D. Medical Examiner
Date signed 8-18-48

VS 191

G65993

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

Registered No. G65993

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Redwood & Greene
(b) Street address [redacted]
(c) Hospital or institution: University Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Oxford St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ethel Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	B	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1893

8. AGE: Years 55 | Months | Days | If less than one day: hr. min.

9. Birthplace S. Carolina (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name James Graham
13. Birthplace S. Carolina

MOTHER
14. Maiden Name Hester Harley
15. Birthplace S. Carolina

16 (a) Informant Thelma Henry
(b) Address 511 Oxford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20-1948 (month) (day) (year)
(c) Cemetery or crematory
Location Lake City, S. C.

18 (d) Funeral director Elmer B. Wilson
(b) Address 1000 Belnitty ave Huntington Station, N.Y.

19 AUG 19 1948 (Date received by Registrar) Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17 1948 at 12:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1948 to 8-17 1948 and that I last saw her alive on 8-17 1948.

Immediate cause of death	Cardiac arrest failure	
Due to	peritonitis	
Due to	Perforated carcinoma of ascending colon.	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation 8-16-48

Major findings of operation: see diagnoses

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature John H Rosser M. D.

Address University Hosp. Balto. 1, Md. Date signed 8-17-48

BSL-2

G65994

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 183a

Registered No. G65994

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 N. CENTRAL Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RUBIN JUDAS GETER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife LETHA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1902

8. AGE: Years	Months	Days	If less than one day
? 46			hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation PAINTER

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17-48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem Brooklyn Md
Location

18 (a) Funeral director Floyd O. Wilson
(b) Address 1100 Broadway at Washington Boulevard

19 (a) AUG 19 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18 1948, at 2.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1948 to 8-18 1948, and that I last saw h[im] alive on 8-18 1948.

Immediate cause of death Cerebrovascular accident, right

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 35 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard S Ross M.D.
Address JOHNS HOPKINS HOSPITAL Date signed 18 Aug 48

Robert B. McFadden, M.D. Parker Merrill MD

VS 150

G65995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G65995

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 65 Ellicott Drive
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-4
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 65 Ellicott Drive
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Henry M. Schwabeland

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Minnie C.

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr) 6-7-1871

8. AGE: Years 77 | Months 1 | Days 8 | If less than one day — hr. — min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Pressman.

11. Industry or business Retired

FATHER
12. Name Andrew Schwabeland.
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude ?
15. Birthplace Germany

16 (a) Informant Minnie C. Schwabeland
(b) Address 65 Ellicott Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director T. Bellistri & Bro.
(b) Address 1700 Eastern Ave.

19 (a) (Signature of registrar) (b) Registrar Washington Williams M.D.
Registrar

AUG 19 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1948 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Aug. 15 1948.
and that I last saw h[illegible] alive on Aug. 13, 1948.

	Duration
Immediate cause of death: Cerebral Hemorrhage	Sudden
Due to Hypertensive cardio-vascular renal disease	2 years
Due to Arteriosclerosis, generalized	2 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert E. Redman, M.D.
Address 2517 W. Balto. St. Date signed 8/15/48
M. D.

665996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1631B

Registered No. 665996

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Avenue
(c) Hospital or institution: St. Agnes Hosp. 25-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 DeSota Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FREDA A. FARREN "FREDA A. FARREN"

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-22-3380

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Thomas J. Farren Sr

6 (c) If alive, give age (years)

7. Birth date of deceased (mo., day, yr.) 12-22-1895

8. AGE: Years 57-52 | Months 8 7 | Days 5 26 | If less than one day: hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation Housewife & Clerk

11. Industry or business Garden Dry Cleaning Co

FATHER
12. Name William Hesterberg
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Schange
15. Birthplace Maryland

16 (a) Informant Son—Thomas Farren
(b) Address 16 N. Kossuth Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20: 48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director J. B. Hilbert & Son
(b) Address 1700 Eutaw Place

19 (a) AUG 19 1948 (Date of this delivery) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, at 5:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Phenobarbital Poisoning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-14-48 at 6:00 P M (?)
(b) Where did injury occur? 121 DeSota Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Ingestion of Phenobarbitol tablets

23. Signature [signature] M.D. Medical Examiner.
Date signed 8-17-48

VS 191

G65997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G65997

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4220 Euclid Ave
(c) Hospital or institution: - - - - - 21 - 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4220 Euclid Ave
(If rural give location)
(e) Citizen of foreign country? U.S.A. (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur L. Sullivan "Sullivan"

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Lorine Locke
6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) 6-26-1891

8. AGE: Years 67 | Months 2 | Days 10 | If less than one day 20 hr. min.

9. Birthplace Tamworth New Hampshire (Town, county, and state)

10. Usual Occupation Commissioner Food & Drugs
11. Industry or business Md. State Health Dept.

FATHER
12. Name Gabriel Henry Sullivan
13. Birthplace Boston - Mass

MOTHER
14. Maiden Name Adriana Whitemore
15. Birthplace Pembroke - Mass

16 (a) Informant Nancy R. Sullivan
(b) Address Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20-48 (month) (day) (year)
(c) Cemetery or crematory Glen Mood
Location Mt. Lemington D.C.

18 (a) Funeral director J. B. Wilkinson & Son
(b) Address 1520 Eutaw Place - 17

19 (a) AUG 19 1948 (Date rec'd by registrar) (b) Huntington, Indiana, Md.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16-48 19..., at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death was:

IMMEDIATE CAUSE OF DEATH Cardio-Respiratory Failure

Due to Hypertensive Cardio vascular disease

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert E. McFadden M.D.
Medical Examiner.
Date signed 8-17-48

C65998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. C65998

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr. 15 min
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2837 Hillen Rd. (A) (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Marian R Poehlman

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband ~~or wife~~ James C. Poehlman
6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr) Aug 27 1899

8. AGE:

Years	Months	Days	If less than one day
48	11	9 22	hr. min.

9. Birthplace Md. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Robt. C. Dudley
13. Birthplace Md.

MOTHER
14. Maiden Name Alice B. Caffrey
15 Birthplace Md.

16 (a) Informant Geo. E. Poehlman
(b) Address 2837 Hillen Rd.

17 (a) Burial (Burial, cremation, or removal) **(b)** Date thereof 8/21/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cathedral
Location Balto.

18 (a) Funeral director E. J. Bowling & Son
(b) Address 1938 E. Lafayette Ave

19 (a) AUG 19 1948 (Date rec'd by registrar) **(b)** Huntington Williams Abell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1948 at 12 45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18-1948 to 8-18-1948, and that I last saw h e r alive on 8-18-1948.

Immediate cause of death Acute congestive heart failure — Duration a few hrs.

Due to acute coronary thrombosis

Due to

Other Conditions ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. D. Thomas, M. D.
Address Mercy Hosp. Date signed 8-18-48

VS 189

X

G65999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G65999

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Avenues
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2560 Frederick Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Schultz

3 (b) If veteran, name war None

3 (c) Social Security Account No. 216-01-7289

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Annie Schultz

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1886

8. AGE: Years 61 | Months 10 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Steel Fabricator

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name John Schultz
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Baig
15. Birthplace Germany

16 (a) Informant Katherine Kopacz
(b) Address 9417 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George F. Eckhardt
(b) Address 2101 Fredeside Ave.

AUG 20 1948 (Date rec'd by registrar)

(Signature) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1948, at 7:41 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1948, to Aug. 19 1948, and that I last saw him alive on 8/19 1948.

Immediate cause of death Acute cardiac failure

Due to secondary septicemia

Due to Adeno-carcinoma of sigmoid colon.

Other Conditions

(Include pregnancy within 3 months of death)

Duration

Date of operation July 29, 1948 - Aug 11, 48

Major findings of operation: Adeno-Ca of Sigmoid Colon

of autopsy: None performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen K. Cashman M. D.

Address St. Agnes Hosp. Date signed 8/19/48

VS 150

G66000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G66000

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 189 Abington Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 189 N. Abington Ave. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME John Frederick Batzer

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Augusta Batzer

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 25, 1853

8. AGE: Years 95 | Months — | Days 24 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state or foreign country)

10. Usual Occupation Shoemaker

11. Industry or business Retired

FATHER

12. Name Unknown

13. Birthplace Germany

MOTHER

14. Maiden Name Unknown

15 Birthplace Germany

16 (a) Informant Henry Batzer

(b) Address 189 N. Abington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-48 (month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore, Md.

18 (a) Funeral director George L. Schwab

(b) Address 2101 Frederick ave

19 AUG 20 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1948, at 10.04 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 24 1941, to Aug 18 1948 and that I last saw him alive on Aug 18 1948

Immediate cause of death: Arteriosclerotic Cardiac degeneration Disease — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)

(e) Means of injury

23. Signature Carl P. Rosting, M.D.

Address 1316 W. Lombard Date signed 8/19/48

VS 150

48-17490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G666001

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legi

E OF DEATH:
altimore City, Maryland

Street address

(c) Hospital or institution:
The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town altimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2451 Brentwood Avenue
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Baby Boy Hilliard (1/40951)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
0	0	1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Nathaniel Harris
13. Birthplace Unknown

MOTHER
14. Maiden Name Pernice Hilliard
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address The Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (b)

AUG 20 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1948, at 6:30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from August 12 1948 to August 13 1948, and that I last saw h im alive on August 13 1948.

Immediate cause of death Subarachnoid Hemorrhages — Duration

Due to Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 8-12-48

Major findings of operation:

of autopsy: Subarachnoid hemorrhages

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature Paul O Burns M. D.

Address The Johns Hopkins Hospital Date signed 8-16, 48

VS 150

066002 SC-4P-128-46 066002

BALTIMORE CITY HEALTH DEPARTMENT

GM. 122026

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1416 Millrace Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cooper Baby Girl (Edith)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8- 11- 48

8. AGE: Years Months Days 4 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Walter Cooper

13. Birthplace Md.

MOTHER 14. Maiden Name Edith Lockner

15. Birthplace Md.

16 (a) Informant Records Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) 9am (b) Date thereof 8-16-48 (month) (day) (year)

(c) Cemetery or crematory Baltimore City Hospitals

Location 4940 Eastern Ave.

18 (a) Funeral director

(b) Address Contractor Williamsport, Md

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15- 1948 at 1:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-11 1948 to 8-15 1948, and that I last saw her alive on 8-15 1948

Immediate cause of death Prematurity (B. Wt. 7 lbs 9 oz

Duration 3 days

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature B. C. [illegible] M. D.

Address B.C. Date signed Aug 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G66003

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days

(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2628 Robb St (If rural give location)

(e) Citizen of foreign country? No ~~Year~~ No

If yes, name country

3 (a) FULL NAME Mrs. William Bill (Cora)

3 (b) If veteran, name war — W

3 (c) Social Security Account No. — None

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife William Bill (dead)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 29, 1885

8. AGE: Years 63 | Months 0 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business —

FATHER 12. Name Mr. Henry Smith

13. Birthplace Delaware

MOTHER 14. Maiden Name Marion E. Hart

15. Birthplace Baltimore, Md

16 (a) Informant Daughter - Mrs. Anna Zink

(b) Address (same) 2628 Robb St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Baltimore Md

18 (a) Funeral director Wilson Cook Co

(b) Address 1219 E Cold St

19 AUG 20 1948 (Date rec'd by registrar) Charlestown Williams Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1948, to Aug 19 1948, and that I last saw her alive on Aug 19 1948.

Immediate cause of death Peritonitis — Duration

Due to Intestinal obstruction & perforation

Due to

Other Conditions Carcinoma of large bowel

(Include pregnancy within 3 months of death)

Date of operation 7/21/48

Major findings of operation: Wound of sigmoid

of autopsy: Peritonitis.

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)

(e) Means of injury

23. Signature Richard L Beach

Address Union Memorial H Date signed 8/19/48 (M.D.)

VS 150

G66004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G66004

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 434 East 21st Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 434 East 21st Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Norbin R. Schuldt

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Henry J. Schuldt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1906

8. AGE: Years 62 | Months 2 | Days 8 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name Frederick Schuldt
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Dinner
15. Birthplace Poland

16 (a) Informant: Henry J. Schuldt
(b) Address 2617 Kingsmith Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1210 E. St. Paul Street

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1948, at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1948, to Aug 19 1948, and that I last saw her alive on Aug 17 1948.

	Duration
Immediate cause of death: Uraemia	2-3 days
Due to Glomerular nephritis	5 mos.
Due to Myocarditis & coronary disease.	1 yr.
Other Conditions Goiter.	2 mo.
Arterial Hypertension.	1 yr.

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Thomas Graham Manton M. D.
Address 516 Cathedral Date signed 8-19-48

G66005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G66005
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 St. Paul Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town, give township or R.F.D. number)
(c) Street No. 1001 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JANE STEWART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thomas A. Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5th 1883

8. AGE: Years 64 Months 11 Days 14 (If less than one day) hr. min

9. Birthplace Cal. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Dunbar Averall
13. Birthplace Maine

MOTHER
14. Maiden Name Lucinda (Unknown)
15. Birthplace Maine

16 (a) Informant Thomas A. Stewart
(b) Address 1001 St. Paul St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month, day, year)
(c) Cemetery Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 AUG 20 1948 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19/48 19 1255 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify)
(d) Means of injury

23. Signature John R. Lewis M.D.
Medical Examiner.
Date signed 8/19/48

VS 151

G66006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66006 / 157a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 936 Abbott Ct #2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Harry J. Young Jr.

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1935

8. AGE: Years	Months	Days	If less than one day
13	5	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation School Boy
11. Industry or business

FATHER 12. Name Harry J. Young Sr.
FATHER 13. Birthplace Baltimore, Md.
MOTHER 14. Maiden Name Mary E. McLain
MOTHER 15. Birthplace Baltimore, Md.

16 (a) Informant Elmer W. Corbin
(b) Address 924 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 1948 (month) (day) (year)
(c) Cemetery or crematory Inter-Cathedral Cemetery
Location 4300 Old Frederick Rd
18 (a) Funeral director Elmer W. Corbin
(b) Address 924 E. Eager St.
19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19, 1948, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1-1948 to 8-19-1948, and that I last saw h(er) alive on 8-19-1948

Immediate cause of death	Duration
Respiratory failure	
Due to Communicating Hydrocephalus	
Due to Block at tentorial incisura	
Other Conditions Severe cortical atrophy (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: 8-19-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature W. A. Kierman M.D.
Address Univ. Hosp. Date signed 8-19-48

VS 150

G66007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 879

Registered No. G66007

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 155 W. Henrietta St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna C. Ellis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Preston Ellis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1886

8. AGE: Years 62 | Months — | Days — | If less than one day: hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Preston Ellis
(b) Address 155 W. Henrietta St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James Castagna
(b) Address 1142 Hollins St

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18/48 19 , at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1948, to 8/18 1948.
and that I last saw HER alive on 8/18 1948.

Immediate cause of death	Duration
CEREBRAL EDEMA	
CEREBRAL SCLEROSIS	
Due to GENERALIZED ARTERIOSCLEROSIS	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel A. Scalia, M.D.
Address So. Balto. Gen. Hosp. Date signed 8/19/48

VS 150

G66008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G66008

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 N. Potomac St
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 N. Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Roth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Annabelle Roth 6 (c) If alive, give age 1840 yrs

7. Birth date of deceased (mo., day, yr) April 27, (1881)

8. AGE: Years 67 68 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Roth
13. Birthplace Germany.

MOTHER 14. Maiden Name Katherine Lampe
15. Birthplace Germany

16 (a) Informant Mrs Annabelle Roth
(b) Address 10 N. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson Ave

18 (a) Funeral director John A. Moran
(b) Address 300 E. Baltimore St.

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1948 at 5:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10, 1948, to Aug 17 1948, and that I last saw him alive on Aug 17 1948.

Immediate cause of death Cardiac asthma. — Duration 2 da

Due to Cerebral Hemorrhage — 6 da

Due to Hematuria — 4 da

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature E. M. Townsend M.D.
Address 1302 St Paul St Date signed Aug 19 1948.

VS 150

G66009

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66009

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 535 N. Luzerne Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) approx 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 N. Luzerne Ave., (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME IDA SIEGEL

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 12, 1887

8. AGE: Years	Months	Days	If less than one day
60	11	6	hr. min.

9. Birthplace New York City (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Jacob Siegel
13. Birthplace Russia

MOTHER
14. Maiden Name Mary Rose
15. Birthplace unknown

16 (a) Informant Miss Carrie Siegel - sister
(b) Address 535 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Congregation
Location Belair Rd., Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) AUG 20 1948 (Date received by registrar) Huntington Williams, M.D.

VS 15)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18- 1948, at 2.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17- 1948 to 8-18- 1948. and that I last saw h/w alive on 8-18- 1948.

Immediate cause of death: Cerebral hemorrhage — Duration: 1 day
Due to: hypertension — 2 years
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence. at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 8-19-48

066010

121262 I.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 066010

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Peel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?-?-? 60?

8. AGE: Years 60? | Months | Days | If less than one day hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name ?
FATHER 13. Birthplace ?

MOTHER 14. Maiden Name ?
MOTHER 15. Birthplace ?

16 (a) Informant Baltimore City Hospitals/-Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 16 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15- 1948, at 9.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-14- 1948, to 7-15- 1948, and that I last saw him alive on 7-15- 1948.

Immediate cause of death: CVA — Duration 12hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury.

23. Signature M. D. Nelson M.D.
Address Baltimore City Hospitals Date signed 7/16/48

G66011

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66011

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hosp. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James KIETH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 86 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 16 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 AUG 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1948, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inq Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Undetermined (decomposed)

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8/6/48

G66012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G66012 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: J. H. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1143 E. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isidore C Lapin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 50 | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof

(c) Cemetery or crematory
Location University Medical School AUG 16 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) AUG 20 1948 (Date received by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 August 1948, at 6:10? M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer 2 M.D.
Medical Examiner
Date signed 9 Aug. 1948

VS 151

66013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66013 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101
(c) Hospital or institution: Johns Hopkins Hospital 3rd W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 436 S. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Watnick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 90 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (mo., day, yr.)
(c) Cemetery or crematory
Location University Medical School AUG 16 1948 Commissioner of Health

18 (a) Funeral director
(b) Address

19 AUG 20 1948 (Date rec'd by registrar) (b) [illegible]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 1948 at 8:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Metastatic Carcinoma of Prostate

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 8/16/48

G66014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66014

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 667 West Mauricia (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER POWELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month)

(c) Cemetery or crematory

Location University Medical School AUG 16 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) AUG 20 1948 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/48 19 at 2015 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work)
(d) Means of injury

23. Signature John R Peters M.D.
Medical Examiner.
Date signed 8/10/48

VS 151

Brestan H. Resau

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

666015 — Registered No. 666015

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1273 E North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1273 E North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Brestan H. Resau

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Jona Resau
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 1877

8. AGE: Years	Months	Days	If less than one day
70	8	23	hr. min.

9. Birthplace Balto Co
(Town, county, and state)
10. Usual Occupation Machinist (Retired)
11. Industry or business

FATHER
12. Name H H Resau
13. Birthplace Md

MOTHER
14. Maiden Name Sophia Knapp
15. Birthplace Md

16 (a) Informant Miss Evelyn Resau
(b) Address 1273 E North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Balto Co Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

19 (a) AUG 20 1948 (Date rec'd by registrar) [illegible] Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 18 1948 at 4 05 P M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio Respiratory failure

Due to Hypertensive Cardio vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. R. McFadden M.D.
Medical Examiner.
Date signed 8-19-48

G66016

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66016 182a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division St
(c) Hospital or institution: Provident Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 da
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 565 Lanvale St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country none

3 (a) FULL NAME Margaret Smith

3 (b) If veteran, name war none
3 (c) Social Security Account No. none

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Samuel Smith
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) 2/2/1882

8. AGE: Years 66 | Months 6 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace West Point, Maryland (Town, county, and state)

10. Usual Occupation Housework
11. Industry or business none

FATHER
12. Name Lewis Blouns
13. Birthplace ?

MOTHER
14. Maiden Name Jane Blouns
15. Birthplace ?

16 (a) Informant Samuel Smith, Husband
(b) Address 565 Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17 19 48, at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1948, to 8-17 1948, and that I last saw h alive on 8-17 1948

Immediate cause of death [illegible]
Cerebro vascular accident (Subarachnoid hemorrhage)
Due to [illegible]

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Provident Hosp Date signed 8-19-48

VS 150

G66017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G66017

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital DOA
(d) Length of stay in hospital or instt. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 543 Lafayette St. W. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence E. White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daisy White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 55 | Months | Days | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Albert White
13. Birthplace: Md.

MOTHER
14. Maiden Name: Hettie Cooper
15. Birthplace: Md.

16 (a) Informant: Mrs. Daisy White
(b) Address: 543 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)
(c) Cemetery or crematory: National Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Mrs. Frances A. Hemsley
(b) Address: 578 W. Biddle St.

19 (Date received by local registrar) AUG 20 1948 (Signature of local registrar) Thurlington Williamson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18, 1948, at 7:10PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: George A. Merrill M.D. Medical Examiner.
Date signed 8/19/48

VS 151

G66018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 1248

G66018 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William WEAVER (Wm. D. Weaver)

3 (b) If veteran, name war --

3 (c) Social Security Account No. ---

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Eva Weaver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1881

8. AGE: Years 66 | Months 10 | Days 21 6 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business:

FATHER
12. Name: Wm. Weaver
13. Birthplace: N.C.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: N.C.

16 (a) Informant: Emil Weaver
(b) Address: 2100 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20/48 (month, day, year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto. Md.

18 (a) Funeral director: Philip Henry Sons
(b) Address: 2024 Orleans St.

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1948, at 11:45 M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic cardiovascular disease.

Fatty degeneration of liver

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: George G. Merrill M.D. Medical Examiner.
Date signed 8/19/48

VS 151

G66019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 471

G66019
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State VIRGINIA (b) County
(c) City or town RICHMOND (If outside city or town limits, write RURAL and give town)
(d) Street No. 2809 GROVE AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME DR. OLIVER BRUNK

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: BERNICE
6 (c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): 9-13-78
8. AGE: Years 69 | Months 11 | Days 6 | If less than one day: hr. min.
9. Birthplace: VIRGINIA (Town, county, and state)
10. Usual Occupation: PHYSICIAN
11. Industry or business:

FATHER
12. Name: CHRISTIAN BRUNK
13. Birthplace: VA.

MOTHER
14. Maiden Name: MARY RALSTON
15. Birthplace: VA.

16 (a) Informant:
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Removal (burial, cremation, or removal) (b) Date thereof 8-20-48 (month) (day) (year)
(c) Cemetery or crematory
Location: Richmond Va.

18 (a) Funeral director: R. J. Tisdale or Amos Doe.
(b) Address: Ro Parkers Bank 12 Ind.

19 AUG 20 1948 (Date rec'd by registrar) (b) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1948, at 10:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23 1948 to 8-19 1948
and that I last saw him alive on 8-19 1948

Immediate cause of death: Empyema, left Chest with Broncho-pleural Fistula & Abcess, Right lower lobe

Due to: Carcinoma, left Lung (Removal at Operation, April 1948)

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation: August 18, 1948

Major findings of operation: Empyema, left Chest & Broncho-pleural Fistula

of autopsy: Same

Duration
2 Months
3 weeks
6 months
years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Wm. C. Worthington
Address: JOHNS HOPKINS HOSPITAL Date signed 8/19/48

VS 150

G66020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G66020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM PETERS Vasilios Prodromou

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-28-2072

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Despina

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER 12. Name Prodromou

13. Birthplace

MOTHER 14. Maiden Name Stamatia

15. Birthplace

16 (a) Informant Kyriakos Prodromou

(b) Address 1400 Wash. Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-48 (month) (day) (year)

(c) Cemetery or crematory Greek Cemetery

Location Windsor Mill Rd.

18 (a) Funeral director Lambros Inc

(b) Address 440 E. North ave

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Baltimore, Md.

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, at 10.10 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [signature] M.D. Medical Examiner

Date signed August 18, 1948

G66021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate before it is filed. Please see that the information you supply is complete and correct. Age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore City. Md
(b) Street address 33rd & Colvert Street
(c) Hospital or institution: Union Memorial Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Garrison Boulevard. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Porter Hatter — Frank Porter Hatter

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-6577

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife Charlotte P. Hatter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1879

8. AGE: Years 69 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Accountant.

11. Industry or business

FATHER
12. Name Charles W Hatter
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Porter
15. Birthplace Baltimore, Maryland.

16 (a) Informant Mrs. Charlotte P. Hatter
(b) Address 3112 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pa. Aves. Balto, 17

19 (a) AUG 20 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 19 1948, at 5.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 15 1948 to Aug - 19 1948, and that I last saw him alive on Aug 19 1948.

	Duration
Immediate cause of death: Cardio - Respiratory Failure	5 days
Due to Coronary Insufficiency	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Smith, Jr. M.D.
Address Union Memorial Hosp. Date signed 8/19/48

VS 150

G66022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66022

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 N. Fayette St
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Florence M. Leizear

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: James Edmund Leizear

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 7/ /1882

8. AGE: Years: 66 | Months: 1 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Frederick Co. Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Samuel D. Myers
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Frances Eader
15. Birthplace: Frederick Co. Md.

16 (a) Informant: Mrs. Ethel L. Herzer
(b) Address: 7111 Sheffield Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 21, 1948 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cemetery
Location: Woodlawn, Md.

18 (a) Funeral director: William J. Tickner & Sons,
(b) Address: North & Pa. Aves.

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Tentatively for Williamsville, Mass.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1948, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1948, to Aug 18 1948, and that I last saw h GR alive on Aug 18 1948.

Immediate cause of death: Heart failure & Circulatory failure — Duration: /

Due to: Cornary Seculain

Due to: Arteriosclerosis

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: William S. Womack M. D.
Address: Bon Secours Hosp. Date signed 8/18/48

VS 180

G66023

AB-95807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G66023

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs

(e) Length of stay in Baltimore (yrs., mos., or days) ? 2yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. ? No Home (If rural give location)

(e) Citizen of foreign country? (Yes or No) /

If yes, name country

3 (a) FULL NAME James Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?-?-?

8. AGE: Years	Months	Days	If less than one day
65 ?			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER

12. Name ?

13. Birthplace ?

MOTHER

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School AUG 19 1948

18 (a) Funeral director Commissioner of Health

(b) Address AUG 20 1948

19 (a) (Date rec'd by registrar) (b) Registrar

VS :50

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9- 1948, at 8A M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-31- 1945 to 8-9- 1948, and that I last saw h in alive on 8-9- 1948

Immediate cause of death Bronchopneumonia — Duration 1 day

Due to

Due to and Cerebrovascular Accident — 6 days

Other Conditions Hypertensive and Arteriosclerotic Cardiovascular Disease — years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Warren E. Rice M. D.

Address Balto City Hospitals Date signed 8/13/48

53a

G66024 JL - 121426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12

Registered No. G66024

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4040 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days

(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 211 China St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1907

8. AGE: Years	Months	Days	If less than one day
41	4	25	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Jefferson

13. Birthplace S. C.

MOTHER 14. Maiden Name Dorothy Stool

15. Birthplace S. C.

16 (a) Informant B.C.H. Records

(b) Address 4040 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location University Medical School AUG 19 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 AUG 20 1948 (Date rec'd by registrar) (b) Filing Number

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7 1948, at 2:45 M

21. I certify that death occurred on the date above stated, that I attended deceased from July 31 1948 to Aug. 7 1948, and that I last saw her alive on Aug. 7 1948.

Immediate cause of death Advanced pneumonia right, probably due to tuberculosis — Duration 3 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature L. Stutzman M. D.

Address Balto. City Hosp. Date signed 8-14-48

Dr. Brennan

666025

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

Registered No. 666025

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Age, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3019 Echodale Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 Echodale Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARGARET A. PUHL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Herman W. Puhl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 17, 1878

8. AGE: Years	Months	Days	If less than one day
70	1	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Frederick J. Hesse
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Thurne
15 Birthplace Germany

16 (a) Informant Mrs. Lillian H. Bringman
(b) Address 3019 Echodale Avenue #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) AUG 20 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Aug 1948, and that I last saw her alive on Aug 19 1948.

Immediate cause of death Cardiac failure — Duration

Due to Generalized Arterio-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Brennan M. D.
Address 5217 Harford Rd Date signed 8-19-48

VS 150

G66026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73

Registered No. G66026

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3222 Dudley Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3222 Dudley Ave
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country 38 years

3 (a) FULL NAME Henry Murphy 18

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-01-4571

4. Sex M | 5. Color or race W. | 6 (a) Single, ~~married~~ widowed, or ~~divorced~~.

6 (b) Name of husband or wife Rosella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 12-1875

8. AGE: Years 73 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation

11. Industry or business Standard Oil

FATHER
12. Name
13. Birthplace England

MOTHER
14. Maiden Name
15 Birthplace England

16 (a) Informant Mrs Catherine Murphy
(b) Address 3222 Dudley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jos D Iden & Son
(b) Address 3001 Kentucky Ave

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Huntington W Va

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18-48 19 , at 4:46 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 48 to 8-18-48 19 , and that I last saw h alive on 8-18-48 19

Immediate cause of death (a) Aplastic Anaemia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. J. McGrath
Address 1E. Randolph St Date signed 8/19/48

Dr. J. McGrath X

G66027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

G66027 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 E. Gittings Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James V. Hooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Lennie C

6 (b) Name of husband or wife: Lyon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/1897

8. AGE: Years 50 | Months 10 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Park Doors

11. Industry or business

12. FATHER Name Benjamin A. Hooker

13. FATHER Birthplace Baltimore

14. MOTHER Maiden Name Lelia Smith

15. MOTHER Birthplace Baltimore Md

16 (a) Informant Mrs J. V. Hooper

(b) Address 107 E. Gittings St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/48

(c) Cemetery or crematory Laurel Park

Location Frederick Rd

18 (a) Funeral director J. J. Foley & Sons

(b) Address 1818 Light St

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1948, at 8:15 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection, or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull with intracranial hemorrhage

Due to Street fight

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-15- at 3.20 P. M.
(b) Where did injury occur? 1842 Light Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public (Saloon) (While at work) no
(d) Means of injury Struck by fist & knocked to pavement.

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 8-19-48

VS 151

WASILJOV

G66028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No. G66028

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 William St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wasiljov

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Wasiljov
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11 - 1882

8. AGE: Years: 66 | Months: 4 | Days: 8 | If less than one day: hr. min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Hochschild Kohn & Co.

MOTHER / FATHER

12. Name Mary Wasiljov, Nicholas

13. Birthplace Hungary

MOTHER

14. Maiden Name Anna KERSCHNER

15. Birthplace Hungary

16 (a) Informant Mrs Mary Wasiljov
(b) Address 230 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway

18 (a) Funeral director J. J. Zahn & Sons
(b) Address 1318 Light St.

19 (c) AUG 20 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19/48 19 . at 1 15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1948. to 8/19 1948
and that I last saw h alive on 8/19/48 19

Immediate cause of death Acute Pancreatitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R. MacDonald M. D.
Address 1213 Light St Date signed 8-19-48

MacDonald

VS 150

G66029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G66029 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 Lancaster St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Lancaster St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Slaba

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 54 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: Wojciech Slaba
13. Birthplace: Poland

MOTHER
14. Maiden Name: Olszewska
15. Birthplace: Poland

16 (a) Informant: Agnes Slaba
(b) Address: 1609 Lancaster St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 21/58 (month) (day) (year)
(c) Cemetery or crematory: Holy Rosary
Location: Baltimore

18 (a) Funeral director: Fred W. Ozmun
(b) Address: 1930 Eastern Ave.

19 (a) AUG 20 1948 (Date filed by registrar) (b) for Hilary J. Mullan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 18 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 . and that I last saw him alive on 8/18/ 1948.

Immediate cause of death: Malignancy intestinal — Duration: 2 yrs.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Dr. Eduard Novak per M. T. Boyd M. D.

Address: Date signed

VS 150

C66030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. C66030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 Brunt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Ida Wilson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/27/1882

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Harford Co. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Stewart
13. Birthplace Harford Co. Md

MOTHER
14. Maiden Name Georgie Anna Stewart
15. Birthplace Harford Co. Md

16 (a) Informant Benson Wilson
(b) Address 1912 Brunt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month) (day) (year)
(c) Cemetery or crematory Aberdeen
Location Aberdeen, Md

18 (a) Funeral director Leo. S. Kelly
(b) Address 1203 Presstman St

19 AUG 20 1948 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1948 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1948 to 8/17 1948 and that I last saw her alive on 8/17 1948.

Immediate cause of death	Duration
Pancreatic Abscess	
Due to Ventral Hernia —	
Due to Intestinal Obstruction	
Other Conditions Arteriosclerosis Uremia Cardiovascular Dis — (Include pregnancy within 3 months of death)	

Date of operation 8/13/48 - 8/15/48

Major findings of operation: Ventral Hernia Intestinal obstruction

Findings of autopsy: Pancreatic Abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marcus W. Moore Sr M.D.
Address Provident Hospital Date signed 8/20/48

VS 150

666031

GK 122138

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

666031 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2551 Flora Str. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Golden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? ?

8. AGE: Years 68 ? Months Days If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER
12. Name John Golden
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Presstman St

19 (a) AUG 20 1948 (b) Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19 1948, at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16- 1948 to 8-19- 1948 and that I last saw her alive on 8-19- 1948

Immediate cause of death Cerebral vascular accident, left — Duration 3 days

Due to Hypertensive Cardio-vascular disease — 2-3 years

Due to

Other Conditions Bronchopneumonia, left lower lobe. — 3 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Probable Bronchopneumonia, left

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Stutzman M. D.
Address Balto. City Hosp. Date signed 8-20-48

EB-122209 G66032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 159

Registered No. G66032

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) N.B.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lee

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 18, 1948

8. AGE: Years	Months	Days	If less than one day
1 day	0	1	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Daniel Lee
13. Birthplace Va.

MOTHER
14. Maiden Name Hilda Chucker
15. Birthplace Va.

16 (a) Informant RECORDS: Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto. County Md.

18 (a) Funeral director Thos. Corr & Sons
(b) Address 1129 N. Caroline St

19 AUG 20 1948 (Date rec'd by registrar) (b) Interring for Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19 48 at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1948 to 8-19 1948
and that I last saw him alive on 8-19 1948

Immediate cause of death: Prematurity — Duration: 12 hrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed Aug 19 48

G66033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

944a

G66033 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 216 E. 39th Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 216 E. 39th Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard O. Buffington

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mary C. Buffington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 24, 1877

8. AGE: Years	Months	Days	If less than one day
71	6	24	hr. min.

9. Birthplace: Carroll Co. Md. (Town, county, and state)

10. Usual Occupation: Seed Merchant Wholesale

11. Industry or business: Retired 20 years

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name: Anna White

15. Birthplace: Md.

16 (a) Informant: Mr. Howard O. Buffington, Jr.

(b) Address: 1338 Crofton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 21, 1948 (month) (day) (year)

(c) Cemetery or crematory: Greenmount Cemetery

Location: Baltimore, Maryland

18 (a) Funeral director: William J. Tickner & Sons,

(b) Address: North & Pa. Aves. Balto. 17

19 (a) (Registered by registrar) AUG 21 1948 Huntington Williams, Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1939 to Aug. 18 1948, and that I last saw him alive on July 23 1948.

Immediate cause of death: Coronary thrombosis — Duration: Suddenly

Due to: Arteriosclerosis — Duration: yrs.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robt. B Wright M. D.

Address Medical Arts Bldg. Date signed 8/19/48.

G66034

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59B

G66034
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the cause of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 E. 29th St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel A. Wise (ETHEL A. WISE)

3 (b) If veteran, name war 1

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Joseph R. Wise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22 75

8. AGE: Years 72 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Dominick Hayden
13. Birthplace Md

MOTHER 14. Maiden Name Catherine Howard
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 118 N. Mt. Royal Ave

AUG 20 1948 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1948, at 7 45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1948 to 8/18 1948.
and that I last saw her alive on 8/8 1948.

Immediate cause of death Gangrenous ulcer, left foot. — Duration 10+ yrs.

Due to Arteriosclerosis, gen., severe

Due to

Other Conditions Osteoarthritis, severe
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature E. W. Smith M.D.
Address JOHNS HOPKINS HOSPITAL Date signed 8/19/48

VS 195

97

G66035

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G66035

CERTIFICATE OF DEATH 170c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. Waterloo Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JESSE DASHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-19-1886

8. AGE: Years 62 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Penn West Virginia (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Jesse V.S. Dasher
13. Birthplace Penn. W. Va

MOTHER
14. Maiden Name Hannah M Cowger
15. Birthplace Fort Lyburn W Va

16 (a) Informant M Dasher
(b) Address Moyfield W Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-48 (month) (day) (year)

(c) Cemetery or crematory Taylorsville
LAYTONSVILLE
Location Taylorsville

18 (a) Funeral director C C Nembhardt
(b) Address Ellicott City Md

19 AUG 20 1948 (Date received by Registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, at 6.50PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull, Intracranial hemorrhage,

Due to

Other Conditions Multiple brush burns and bruises (Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-17-48 at approx. 1.35AM.
(b) Where did injury occur? half a mile north of Rt. 175 on Wash. Blvd.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? No
(d) Means of injury truck and truck collision

23. Signature Howard J. Mullen M.D. (Medical Examiner)
Date signed August 18, 1948

G66036

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 183

G66036 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) All Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Forrest St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 28 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Jt. Worker

11. Industry or business

FATHER
12. Name Daniel Johnson
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ethel Brown
15. Birthplace Baltimore Md

16 (a) Informant Edgar Johnson
(b) Address 1118 64 Ave Elderon Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentley Ave

19 (a) AUG 20 1948 (Date filed by registrar) Huntington Williams, M.D.

VS 15t

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1948, at 6.45 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-15-48 at approx. 6 P.M.
(b) Where did injury occur? B & O R.R. siding at Potte St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Place While at work? No
(d) Means of injury Fell overboard

23. Signature Medical Examiner. M.D.
Date signed August 16, 1948

G66037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered, or the certificate will be returned for correction. Use figures for dates, ages, etc. Be sure that the cause of death is stated so that it can be understood, and that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James R. Bracken

3 (b) If veteran, name war: No
(c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b). Name of husband or wife: Mary E. Bracken
6 (c) If give, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9. 1906

8. AGE: Years	Months	Days	If less than one day
42	6	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business Plumbing

FATHER
12. Name John F. Bracken
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie C. Wendt
15. Birthplace Germany

16 (a) Informant Mrs Mary E. Bracken
(b) Address 506 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-1948 (month) (day) (year)
(c) Cemetery or crematory Morland Park Cemetery
Location Taylor Ave Dalesland Rd

18 (a) Funeral director Edward W. Conklin
(b) Address 2265 E. Eager St.

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Aug. 1948, at 12.45 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D. Medical Examiner.
Date signed 20 Aug. 1948

G66038

GM.121228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G66038

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered, if unknown, so state. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3824 Fait Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME [redacted] MARY BARBARO

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April- 22- 1867

8. AGE: Years 81 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name DOMINIC BARBARO
13. Birthplace ? ?

MOTHER
14. Maiden Name CHRISTINE ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-21-48. (month) (day) (year)
(c) Cemetery or crematory SACRED HEART CEM. Location GERMAN HILL RD.

18 (a) Funeral director Charles L. Zeiler
(b) Address 901 S. Conkling St.

19 (a) AUG 20 1948 (Date received by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 -19- 1948 at 5.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7- 13- 1948 to 8- 19- 1948, and that I last saw h er alive on 8- 19 - 1948

Immediate cause of death Bronchopneumonia — Duration 9 days

Due to Cerebral Vascular Accident — 5 weeks

Due to Hypertensive Arteriosclerotic Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Viles J. M. D.
Address Balto City Hosp Date signed 19 Aug 48.

VS 132

X

G66039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G66039 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Have correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 Leadenhall Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Leadenhall Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry W. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/19/1880

8. AGE: Years	Months	Days	If less than one day
68 67	3	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Elevator Operator

11. Industry or business

FATHER
12. Name William Smith
13. Birthplace Baltimore, Md,

MOTHER
14. Maiden Name Charlottie Hopkins
15. Birthplace Virginia

16 (a) Informant Ida Smith
(b) Address 804 Leadenhall Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, City.

18 (a) Funeral director Daniel L. Brown & Son
(b) Address 108 W. Monument St. Baltimore, Md.

19 (a) Date received 1948 (b) Registrar

AUG 21 1948

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1948, at 12-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11 1948 to 8-18 1948, and that I last saw him alive on 8-18 1948.

Immediate cause of death Myocardial degeneration — Duration —

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Franklin Culkin M. D.
Address 1543 Penna. Ave Date signed 8/20/48

G66040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G66040 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lena Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February, 1898

8. AGE: Years	Months	Days	If less than one day hr.	min.
50	6			

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Oiler
11. Industry or business Western Md. Coal Pier Co.

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Anna Wheeler
15. Birthplace Virginia

16 (a) Informant Lena Johnson (W)
(b) Address 722 S. Charles Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co., Md.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W. Montgomery Street

19 (a) 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18/48 19 at 7 15 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/15/48 19 to 8/18 19 48. and that I last saw h i m alive on 8/15 19 48.

Immediate cause of death Postal cirrhosis ? cause — Duration ? mos.
Due to
Due to
Other Conditions Chronic pyelonephritis ? mos. Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn O. Summerlin M. D.
Address Balto. Gen. Hosp. Date signed 8/19/48

VS 150

G66041

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G66041 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 17 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 111 S. Spring St. (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country:

3 (a) FULL NAME: WILLIAM TOWNSEND

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.: 212-22-6118

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Townsend
6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): July 12, 1891

8. AGE: Years: 57 | Months: 1 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name: John Townsend
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Martha Cox
15. Birthplace: Maryland

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof: Aug 23. 1948. (month) (day) (year)
(c) Cemetery or crematory: U. S. National
Location: Finedyke and Crooked Hilapel Roads
18 (a) Funeral director: Frederick Memorial Park
(b) Address: 312 E. Highland Ave.
(c) AUG 20 1948 (Date rec'd by registrar) (d) Remington, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 1948, at 12:20 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 2 1948 to Aug. 19 1948, and that I last saw him alive on Aug. 19 1948.

Immediate cause of death: Probable carcinoma of left breast with metastases — Duration:
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 8/19/48

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be sure to answer all questions. Be sure to give correct age in especially important.

VS 180

G66042

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66042
Registered No.

B-122118

1/24a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 323 Castle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1900

8. AGE: Years	Months	Days	If less than one day: hr.	min.
47 (48) 47	11	4		

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Barbara Bondro
15. Birthplace Md.

16 (a) Informant RECORDS-Balto. City Hospital
(b) Address 4940 Eastern Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Aug 21 1948 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location Edmondson Ave.

18 (a) Funeral director Rendell & Leopold
(b) Address 3125 Harford Ave

19 (a) 8 1948 (Date received by registrar) (b)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18 1948, at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14 1948, to 8-18 1948, and that I last saw h[illegible] alive on 8-18 1948.

Immediate cause of death: Rupture of oesophageal ulcer ?

Due to: Cirrhosis

Due to: Alcoholism ?

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. F. Nelson M.D.

Address Date signed 8/18/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Each item is important, and may be required in a court of law. Please answer every question. Be sure your answer is correct and complete. Do not abbreviate. Write out the full name of the city, town, or county. Do not use ditto marks. If unknown, say so. Do not leave any item blank. Cause of death is especially important. Physicians: please write the cause of death clearly and legibly.

G36043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

G36043

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Foot of Boston St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County Salem
(c) City or town Elmer
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Flanagan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~ Married

6 (b) Name of ~~husband or~~ wife May Smith Flanegan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7th 1927

8. AGE: Years 21 | Months 0 | Days 12 | If less than one day hr. min.

9. Birthplace Elmer N. J.
(Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER
12. Name Harry Flanegan
13. Birthplace Auburn N. J.

MOTHER
14. Maiden Name Clarissa Mickle
15. Birthplace Deerfield N. J.

16 (a) Informant B. L. Cristy
(b) Address Elmer N. J.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/20/48 (month, day, year)

(c) Cemetery or crematory Dare Town Presbyterian
Location " N. J.

18 (a) Funeral director William Cook Inc.
(b) Address 217 S. Penn St.

19 AUG 20 1948 (Date rec'd by Registrar) [signature] Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH August 20, 1948 at 11:05 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

probable X

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury August 19, 1948 M.
(b) Where did injury occur? Foot of Boston St.
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? No
(d) Means of injury Drowning

23. Signature George G. Merrill M.D
Medical Examiner.
Date signed 8-20-48

VS 151

G66044 Bal 6
471316

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
52a

G66044
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not abbreviate. Give full name of deceased. If not in hospital or institution, give residence. Give correct age in years, months, days, hours, or minutes, as the case may be. Do not use ditto marks. Answer each question. If unknown or not applicable, write none. Physicians: please write the causes of death clearly and legibly. Cause of death must be certified for any deaths occurring without medical attendance. Coroners: please write the cause of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Cecil Co
(c) City or town Elkton (If outside city or town limits, write RURAL and give town)
(d) Street No. 227 W. High St (If rural, give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Trimble

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Martin
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr) 5-8-86

8. AGE: Years	Months	Days	If less than one day
62	3	12	hr. min

9. Birthplace Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William Trimble
13. Birthplace Pa.

MOTHER
14. Maiden Name Eliza ?
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)
(c) Cemetery or crematory ELKTON
Location ELKTON, Md

18 (a) Funeral director H. W. Pusey & Son
(b) Address Elkton Md

19 (a) AUG 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20- 1948, at 3:55 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16- 1948 to 8-20- 1948 and that I last saw him alive on 8-20 1948

Immediate cause of death: Coma + Shock — Duration
Due to: Carcinoma of rt Kidney
Due to: ? Hypernephroma.
Other Conditions: ? Cerebral metastasis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Ca of Kidney.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Evan Calkins M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

VS 190

G66045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66045

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1721 Linden Ave.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County Southampton
(c) City or town Saltville Va. (If outside city or town limits, write RURAL and give county) Smyth Co
(d) Street No. Baltimore Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Wiley Luther Williams

3 (b) If veteran, name war: None

3 (c) Social Security Account No. — ?) —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Virginia Williams

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr): About 1884

8. AGE: Years: About 64 | Months: 0 | Days: 0 | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Spoke Filler

11. Industry or business: Madison Alkali Co

FATHER
12. Name: Thomas M Williams
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Elizabeth Frader
15. Birthplace: Virginia

16 (a) Informant: Louis E Williams (son)
(b) Address: 1721 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 21-48 (month) (day) (year)
(c) Cemetery or crematory: Saltville
Location: Saltville Va.

18 (a) Funeral director: Sullivan Mortuary
(b) Address: 108 W 37th Ave

19 (a) AUG 21 1948 (Date rec'd by registrar) (b) Funeral for Williams, Wiley

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 Aug 1948, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to 20 Aug 1948, and that I last saw him alive on 19 Aug 1948.

Immediate cause of death: Acute Lymphatic Leukemia — Duration: 5 mos.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Langston L Fearn MD M.D.
Address: 1938 Linden Ave Date signed: 20 Aug 1948

VS 150

666046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. 666046

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4014 Bonner Road
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4014 Bonner Road (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** STELLA OBERMANN

3 (b) If veteran, name war ********

3 (c) Social Security Account No. 214-01-2757

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 - 9 - 1890

8. AGE: Years	Months	Days	If less than one day
57	9	9	********** min.

9. Birthplace Millwaukee Wiscon. (Town, county, and state)
10. Usual Occupation ------
11. Industry or business ------

FATHER
12. Name Phillip Obermann
13. Birthplace Wiscon.

MOTHER
14. Maiden Name Pauline Bellman
15. Birthplace Wiscon.

16 (a) Informant Miss Cora Obermann
(b) Address 4014 Bonner Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 21/48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director H. B. Kephart & Son
(b) Address 1300 EUTAW PLACE. ...17.

19 (a) AUG 21 1948 (Registered by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 18th. 1948 4:30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from may 28 19 to aug 18 19 48, and that I last saw her alive on aug 17 19 48.

Immediate cause of death Carcinoma Uterus — Duration about 5 yrs

Due to

Due to Metastasis in liver tete

Other Conditions Anemia secondary — about 6 mo

(Include pregnancy within 3 months of death)

Date of operation 1943

Major findings of operation: Carcinoma of uterus

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hattie D. Hildt M. D.
Address Garrison Blvd Date signed

PLEASE WRITE PLAINLY, WITH INK OR INDELIBLE PENCIL. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66047

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G66047
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2005 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2005 W. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1872

8. AGE: Years	Months	Days	If less than one day
76	-	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Lindeburg
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Florence Johnson
(b) Address 2005 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 5708 W. Biddle St.

19 (a) AUG 21 1948 (Date rec'd by registrar) Registrar for Williams Mgr

MEDICAL CERTIFICATION A

20. DATE OF DEATH August 19, 1948 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1948 to Aug 19 1948, and that I last saw he alive on Aug 18 1948.

Immediate cause of death Arteriosclerotic Heart Disease — Duration 7

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William M. Carnes M. D.
Address 753 Cargill Date signed 8/20/48

VS 150

G66048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G66048 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave.
(c) Hospital or institution: Convalescence Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2132 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Brown

3 (b) If veteran, name war | 3 (c) Social Security Acct. No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	C	W

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1863

8. AGE: Years	Months	Days	If less than one day: hr.	min.
85	5	22		

9. Birthplace Harford Co. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Isaac Hall
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Arthur R. Johnston
(b) Address 2539 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 21 1940 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon Cem.
Location Harford Co. Md.

18 (a) Funeral director Mrs. Kemp & Mrs. Caulk
(b) Address 1631 Druid Hill Ave.
Huntingtown Williamsport, Md.

AUG 21 1940 (Date rec'd by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1940, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15, to Aug 17 1940, and that I last saw alive on Aug 17 1940.

Immediate cause of death: Cerebral hemorrhage

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burnside

Address 2132 Druid Hill Ave. Date signed Aug 17 1940 M.D.

VS 150

G66049 PEAKER

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46B

G66049 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Joseph Peaker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
52	1	13	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Peaker
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Matilda Jackson
15. Birthplace Baltimore, Md

16 (a) Informant Sister (Relationship) Mrs. Parker
(b) Address 1409 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Chas. H. Goldsborne
(b) Address 1631 Druid Hill Ave

19 (a) AUG 21 1948 (Date rec'd by registrar) (b) Thurlington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18, 1948, at 11:57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22 1947, to 8-18 1948, and that I last saw him alive on 8-18 1948.

Immediate cause of death Carcinoma of Stomach with wide spread metastasis - gastrectomy, ...

Due to (secondary) Extended autonecrosis; Coronary ... and Nephrosclerosis

Other Conditions Bronchopneumonia and Edema of Pulmonary Congestion and ... Cachexia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

... of autopsy:

Duration
...
...
...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Simon N. Carter, jr. M.D.
Address Provident Hospital Date signed Aug 18 1948

G66050

48-03 32)

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH (1950)

Registered No. G66050

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 W. Lexington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD A. ROBINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1948

8. AGE: Years | Months 6 | Days 4 | If less than one day hr min.

9. Birthplace Balto Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Matthew Drake

13. Birthplace N. Carolina

MOTHER 14. Maiden Name Evelyn Robinson

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Alice Robinson (Mother)

(b) Address 1528 N. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23, 1948 (month, day, year)

(c) Cemetery or crematory Pleasant Rest.

Location Towson, Md.

18 (a) Funeral director Mrs. Lounye A. Wells

(b) Address 1431 Druid Hill Ave.

19 (a) AUG 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1948, at 8:35 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)

by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

due to aspiration of vomitus

Other Conditions Intestinal obstruction due to mesenteric hernia (Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-19-48 Approx. 7:00 P M.

(b) Where did injury occur? 628 W. Lexington Street

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No

(d) Means of injury Aspiration of vomitus

23. Signature Earl K. Hoyer M.D. Medical Examiner.

Date signed 8-20-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Fill in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

Registered No. G66051

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 N. Carey St
(c) Hospital or institution: Provident Samaritan Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Spelman Rd (If rural give location) CHERRY HILL
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Washington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 1898

8. AGE: Years	Months	Days	If less than one day
50	1	3	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Washington
13. Birthplace Va

MOTHER
14. Maiden Name Susan Washington
15. Birthplace Va

16 (a) Informant Clara Johnson
(b) Address 2903 Spelman ave Cherry Hill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto Co

18 (a) Funeral director Raymond Sanders
(b) Address 1412 E. Preston St

19 AUG 21 1948 Huntington Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1948 at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 1948 to Aug 18 1948 and that I last saw h[illegible] alive on Aug 17 1948.

Immediate cause of death Uraemia Coma — Duration 2 days

Due to Chronic Interstitial Nephritis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
Accident, suicide, or homicide
(a) Date of occurrence at AM
(b) Where did injury occur? (City or town) (County) (State)
(c) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(d) Means of injury

23. Signature Helen Thomas M. D.
Address 2 Gramercy Ave Date signed 8-21-48

G66052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G66052

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 St. Paul Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME RACHAEL MERLEES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	widowed

6 (b) Name of husband or wife Martin Merlees
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30 ?

8. AGE: Years	Months	Days	If less than one day
about 70			hr. min.

9. Birthplace Stavanger, Norway (Town, county, and state)
10. Usual Occupation masseuse
11. Industry or business

FATHER
12. Name Abraham Topdahl
13. Birthplace Stavanger, Norway

MOTHER
14. Maiden Name ?
15. Birthplace Stavanger, Norway

16 (a) Informant: Einar Merlees
(b) Address 1106 Andover Road

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8/21/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) AUG 21 1948 (Date rec'd by registrar) Functioning for Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 19 48 at 4:35 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to carbon monoxide poisoning

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-19-48 at 3:00 P M.?
(b) Where did injury occur? 2811 St. Paul St.
(c) Did injury occur at home, on farm, in industrial place, in public place? Home While at work? No
(d) Means of injury 4 burners on on stove but unlit.

23. Signature per Robert E. McFadden, M.D. M.D. (Medical Examiner)
Date signed 8-20-48

660053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

660053 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 E. Montgomery St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 E. Montgomery St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Archie Eugene Butler

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 13, 1876

8. AGE: Years 72 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Glass Co.

FATHER
12. Name Edward H. Butler
13. Birthplace Md

MOTHER
14. Maiden Name Georgiana Crandall
15 Birthplace Md

16 (a) Informant Bernard E. Butler
(b) Address 112 E. Montgomery St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Annapolis Blvd

18 (a) Funeral director John F. Kenney Inc
(b) Address 745 Light St.

19 (a) AUG 21 1948 (Date received by registrar) (b) Carrington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1948 at 10 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6, 1948 to Aug 19 1948 and that I last saw him alive on Aug 19 1948.

Immediate cause of death: Chronic myocarditis with edema — Duration 15 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James E. Peterman
Address 1226 Hanover St Date signed M. D. 8/20/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 189

660054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

660054 Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Hamilton Ave Apt 14
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry C. Westerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of husband or wife Deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26 1874
If less than one day hr. min.

8. AGE: Years 74 Months 2 Days 25

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation None (Retired)
11. Industry or business

FATHER
12. Name William Westerman
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Kilian
15. Birthplace Germany

16 (a) Informant Deceased
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-22-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Taylor Ave.

18 (a) Funeral director John C. Miller Inc.
(b) Address 2435 E. Oliver St

19 (a) AUG 21 1948 (Date received by Registrar) Hamilton Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20 — 1948, at 1:00 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from July 20, 1948, to Aug. 20 1948, and that I last saw him alive on 8-19-1948.

Immediate cause of death	Duration
Uremia	2 wks.
Due to Renal Failure	2 wks.
With Vesical Neck Obstruction, Pyelitis and Pyelonephritis	1-2 weeks
Other Conditions Adenoma of Prostate, Cancerous changes	

(Include pregnancy within 3 months of death)

Date of operation 7-27-48

Major findings of operation: Enlarged Prostate gland.

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify) (Yes or No)
(e) Means of injury

23. Signature C. H. Thomsen M.D.
Address Mercy Hosp. Date signed 8-20-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

Vs 150

G66055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G66055

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 N. Stricker St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 107 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY R POWELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-31-1882

8. AGE: Years 66 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James F. McGowan
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth J. Feaney
15. Birthplace Delaware

16 (a) Informant James F. McGowan
(b) Address 2513 Market St Wilm Del

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 8-23-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Wilmington Del

18 (a) Funeral director John J. Moran
(b) Address 3600 E. Baltimore St

19 (a) AUG 21 1948 (Date received by registrar) Wilmington Delaware

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/48 19 at M

21. I certify that I took charge of the remains described above, held an Inspection + Inq thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.
obesity

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M
(b) Where did injury occur?
(c) Did injury occur in home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George C. Merrill M.D.
Medical Examiner.
Date signed 8/20/48

VS 151

G66056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G66056

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct and is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 South Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH COSTELLO JOSEPH ELWOOD COSTELLO

3 (b) If veteran, name war None

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clara Fitzgerald Costello

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 3, 1873

8. AGE: Years 75 | Months 5 | Days 17 16 | If less than one day hr. min.

9. Birthplace Media, Pa. (Town, county, and state)

10. Usual Occupation Manager

11. Industry or business R. W. Norris Co.

FATHER
12. Name ? Costello
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Clara L. Costello
(b) Address 1817 South Rd.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 8/23/48 (month) (day) (year)
(c) Cemetery Greenmount
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS IN
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) [illegible] Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1948, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 8 1948 to Aug 19 1948, and that I last saw him alive on Aug 19 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Pneumonia Subdural Hemorrhage	
Due to Hypertension	
Due to	
Other Conditions Pulmonary Edema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Kot M. D.
Address Sinai Hospital Date signed 8/20/48

VS 150

G66057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133B

Registered No. G66057

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Use figures for dates, ages, etc. Where no entry is required, write "None," "Not applicable," or "Unknown," as the case may be. Physicians: please write the causes of death clearly and legibly. Give the exact cause of death, not the mode of dying, such as heart failure, asthenia, etc. Please do not abbreviate. Be sure that the age, occupation and residence are stated for every person, whether or not he was a laborer, housewife, or unemployed. If the deceased was a housewife, the occupation should be given as housewife. Please state the name of the street and number of the house in which the deceased had lived. Do not report the address of the hospital or institution unless the deceased had lived there for a sufficient length of time to establish residence therein. Please see that your certificate is complete and correct in every detail. Do not fail to sign your name and address.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Balto. City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 222 S. Broadway (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** John Lawrence O'Bryan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Catharine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25, 1883

8. AGE: Years 64 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Md. (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Balto City

FATHER

12. Name Patrick O'Bryan

13. Birthplace Md.

MOTHER

14. Maiden Name Mary Donovan

15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Lilly & Gilen Sts

18 (a) Funeral director 450 S. North Ave

(b) Address Easton Md

19 (Date rec'd by registrar) SEP 21 1948 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19 1948, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1948 to 8-19 1948, and that I last saw h alive on 8-19 1948

Immediate cause of death Hemoglobinuria

Hemoglobinuria

Duration days

Due to

Due to

Other Conditions acute urinary retention

(Include pregnancy within 3 months of death) 2 days

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Gordon Craft M. D.

Address Balt City Hosp. Date signed 8/19/48

VS 150

G66058

G66058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos 28 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town College Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7206 Dartmouth Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Ingram Oswald

3 (b) If veteran, name war No
3 (c) Social Security Account No. No

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Anna E. Oswald
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) July 30, 1883

8. AGE: Years 65 | Months 0 | Days 22 | If less than one day hr. min.

9. Birthplace Cheriton, Md.
(Town, county, and State)

10. Usual Occupation Asst. Dir. extension service
11. Industry or business Univ. of Maryland

FATHER 12. Name Daniel Oswald
13. Birthplace Cheriton, Md.

MOTHER 14. Maiden Name Virginia Ingram
15. Birthplace Maryland

16 (a) Informant Henriette Bess Oswald
(b) Address 7206 Dartmouth Ave College Park Md

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 24 1948 (month) (day) (year)

(c) Cemetery or crematory Hyattsville
Location Hyattsville, Md.

18 (a) Funeral director Francis Leach Sons
(b) Address Hyattsville, Md.

19 (a) Date received by registrar AUG 22 1948 (b) Registrar Centerville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1948 at 4.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948 to Aug 1 1948
and that I last saw him alive on Aug 19 1948

	Duration
Immediate cause of death Respiratory Arrest	
Due to metastatic carcinoma of right clavicular lymph nodes	symptoms since May 1, '48
Due to Carcinoma of Stomach with intestinal obstruction	at least 4 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1944 - Biopsy of (illegible) May 28, 1948 - Exploratory Laparotomy
Major findings of operation: May 28, 1948 metastatic nodules in liver
of autopsy

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify in each place)
(e) Means of injury

23. Signature J. R. Hamtramck M. D.
Address Univ. Hosp. Baltimore-1, Md.
Date signed 8/21/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G66059
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Southern Hotel (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles K. Ditman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Rachel Ditman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1862

8. AGE: Years	Months	Days	If less than one day
Abt. 86			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation C. P. A.
11. Industry or business Self

FATHER
12. Name William H. Ditman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Henry J. Mitchell
(b) Address Southern Hotel

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director C. W. Lamoreau
(b) Address 4510 Liberty Heights Ave.

19 (a) (Date rec'd by registrar) (b) Registrar
AUG 22 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1948 at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1948, to Aug. 20 1948, and that I last saw him alive on Aug. 15 1948

Immediate cause of death Intestinal malignancy — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. H. Patterson M. D.
Address 2324 Reisterstown Rd Date signed 8/21/48

G66060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170a

Registered No. G66060

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3653 Dolfield Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL STERN (DANIEL STERN.)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Christie Stern.
6 (d) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.20, 1876.

8. AGE: Years 72 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired Insurance

11. Industry or business Salesman.

FATHER
12. Name Jacob Stern,
13. Birthplace Germany.

MOTHER
14. Maiden Name Yetta Diebach,
15. Birthplace Germany.

16 (a) Informant Mr. Jerome Stern,
(b) Address 3653 Dolfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/48. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto, Md.

18 (a) Funeral director Sharff Funeral Home
(b) Address 1902 Eutaw Place, Baltimore, Md.

8 Da 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1948 at 11A M 28

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed head with avulsion of brain, Crushed chest and pelvis

Due to

Other Conditions Other fractures, lacerated and ruptured organs with internal hemorrhage. Multiple ragged wounds, brush burns, etc. (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15/11 over

(a) Date of injury 8-20-48 at age of 72 yrs. 9:50 A.M.
(b) Where did injury occur? Western Maryland Crossing - Lewin Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? R. R. Prop. While at work? yes
(d) Means of injury Truck and train collision Ped. struck by train

23. Signature Thomas J. Mullen M.D. Medical Examiner.
Date signed 8-20-48

VS 181

G66061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G66061 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Usual address is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Marlborough Apts. 1411
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE STRAUSS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1882.

8. AGE: Years	Months	Days	If less than one day
66	2	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation Retired Clothing Sales-
11. Industry or business man

FATHER
12. Name Joseph Strauss,
13. Birthplace Germany.

MOTHER
14. Maiden Name Fannie Stern,
15. Birthplace Frederick, Md.

16 (a) Informant Mrs. N. Epstein,
(b) Address Atlantic City, N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/48. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Levin and Levin & Sons
(b) Address 1902 Eutaw Place.
(c) Date received by registrar AUG 24 1948 (d) Signature of registrar Livingston Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21st. 1948, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1948 to Aug. 21 1948. and that I last saw h[illegible] alive on Aug. 20 1948.

Immediate cause of death Coronary Thrombosis — Duration

Due to Cardio-Vascular Disease Atherosclerosis

Due to

Other Conditions Convales. Cerebral Hemorrhage (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis L Jacob M. D.
Address 1700 Eutaw Pl. Date signed Aug. 24 '48

VS 150

G66062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G66062

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 27 North Carey Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 East Arlington ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada E. Waddy Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife John C. Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 22 1896

8. AGE: Years	Months	Days	If less than one day
51	11	22	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Dennis
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Mamie Agnella
15. Birthplace Frederick Maryland

16 (a) Informant John C. Thomas
(b) Address 911 East Arlington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 25 1948 (month) (day) (year)
(c) Cemetery or crematory Dalestus Memorial Park
Location Baltimore County Maryland

18 (a) Funeral director Joseph A. Foley
(b) Address 640 West Baltimore Street

Filed Aug 19 1948 by registrar [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1948 at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1948 to Aug 18 1948 and that I last saw h alive on Aug 18 1948.

Immediate cause of death	Duration
Carcinoma, Uterus	Some days
Due to Breast Cancer	2
Due to	
Other Conditions Fatal Weakness	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

29. Signature [illegible] M. D.
Address 753 W. Fayette Date signed Aug 19 48

G666063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146E

G666063

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Holmes Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Bernard H Kaminsky

3 (b) If veteran, name war —

3 (c) Social Security Account No. .....

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 70 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation none

11. Industry or business .....

FATHER
12. Name Abraham
13. Birthplace Austria

MOTHER
14. Maiden Name Hannah
15. Birthplace Austria

16 (a) Informant Dept Records
(b) Address .....

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 22 1944 (month) (day) (year)

(c) Cemetery or crematory Beth Jacob
Location Wabash Ave & Belvedere Rd

18 (a) Funeral director Jacob Louis Son
(b) Address 1210 E Eutaw Place

19 (a) 8 22 1944 (b) .....
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1944; at 4 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 1944, to 8-22 1944, and that I last saw him alive on 8-22 1944.

Immediate cause of death Coronary Thrombosis

Due to .....

Due to .....

Other Conditions Ca of Sigmoid

(Include pregnancy within 3 months of death)

Date of operation 8-9-44

Major findings of operation: Ca of Sigmoid

of autopsy .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Roger Sorrell M. D.

Address .....

Date signed 8-23-44

G66064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G66064 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
SINAI HOSPITAL BALTIMORE MD. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 Ridgewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE BURGAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex ♀ F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married.

6 (b) Name of husband or wife Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 79 | Months | Days | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Gilbert
13. Birthplace Austria.

MOTHER: 14. Maiden Name not known
15. Birthplace Austria

16 (a) Informant Jacob Burgan
(b) Address 2815 Ridgewood Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8-22-48 (month) (day) (year)

(c) Cemetery or crematory Rebrew Orang Mem
Location Woodsor Mill Road

18 (a) Funeral director Jack Kaufman Inc
(b) Address 2100 Eutaw Place

19 (a) AUG 20 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20 1948 at 2 35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1948 to Aug 20 1948, and that I last saw he alive on Aug 20 1948.

Immediate cause of death Cerebrovascular accident - left.
Due to hypertension arteriosclerosis
Due to generalized arteriosclerosis
Other Conditions malnutrition
an. luminalis
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy: not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliott Harris /CM Shuster M. D.
Address [illegible] York Date signed 8/20/48

G666065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G666065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2429 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hyman Dworkin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 67 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Benjamin
13. Birthplace Russia

MOTHER
14. Maiden Name Naomi
15. Birthplace Russia

16 (a) Informant Isadore Malmow
(b) Address 2429 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1948 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1948, to Aug 20 1948, and that I last saw him alive on Aug 20 1948.

Immediate cause of death Coronary insufficiency — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 18

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roger Hall M. D.
Address Sinai Hosp. Date signed Aug 20 '48

VS 150

G66066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G66066
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 N. Payson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ray Levy

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Benjamin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace England

MOTHER
14. Maiden Name Not Known
15. Birthplace England

16. (a) Informant Bernard Spurrier
(b) Address 1600 Eareckson Pl

17. (a) Burial (b) Date thereof Aug 22, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Workmen Circle
Location Mt. Carmel

18. (a) Funeral director Jack Levin Inc
(b) Address 2108 Eutaw Pl

19 (a) 1948 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-21 1948, at 3:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 1948, to 8-21 1948, and that I last saw h. alive on 8-21 1948.

Immediate cause of death Myocardial insufficiency — Duration

Due to Coronary sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome Gaber M. D.
Address Sinai Hospital Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

VS 130

G66067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G66067
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as far as possible. Use additional sheet if necessary, but do not omit any item. Information is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution 2813 Sunset Drive
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MdD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 Sunset Drive
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Lomax Walter Poole

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-098306

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Blanche

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 1884

8. AGE: Years 64 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Steple Jack

11. Industry or business

FATHER
12. Name Allen J
13. Birthplace Va

MOTHER
14. Maiden Name Mary B Elliott
15. Birthplace Va

16 (a) Informant Wife
(b) Address 2813 Sunset Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Richlin Hgts

18 (a) Funeral director Edward L Foulkrod
(b) Address 2359 Wash Blvd

(Date received by registrar) (Registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Aug. 1948 at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June, 1946 to Aug 1948. and that I last saw living alive on 20 Aug 1948.

Immediate cause of death Coronary Artery Occlusion — Duration 2 yrs.

Due to Severe Arteriosclerosis

Due to

Other Conditions Carcinoma, gastric — 8 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Bayless M. D.
Address 1600 Wilkens Ave Date signed 21 Aug 48

gda

G66068

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66068
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun
(c) Hospital or institution: Franklin Sq Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Snow Hill Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Love

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fe | 5. Color or race: Colored | 6 (a) Single, (Married) widowed, or divorced: Married

6 (b) Name of husband or wife: Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9 1908

8. AGE: Years 39 40 | Months 9 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Richard Allen
13. Birthplace Md.

MOTHER
14. Maiden Name Lillian Hawkins
15. Birthplace Md.

16 (a) Informant Husband
(b) Address Brooklyn, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A.A. County Md.

18 (a) Funeral director Mc Roth & Elliott Dept
(b) Address 1129 N Caroline St

AUG 2 1948 (b) [illegible] registrar
(Date filed) (By registrar)

Courtesy for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19 1948 at 2 50 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1948, to 8-19 1948, and that I last saw her alive on 8-19 1948

Immediate cause of death: Cerebral hemorrhage — Duration: 10 hr.
Due to: Hypertensive C.V. disease
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature A. J. Laham M. D.
Address Franklin Sq Hospital Date signed 8-19-48

G66069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

G66069
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered; if none, say so. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Chapelgate Lane
(c) Hospital or institution: Pine Crest Sanatarium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 S Chapelgate Lane (If rural, give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Georgeanna Cole

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife J Best Cole
(c) If alive, give age 80 years
7. Birth date of deceased (mo., day, yr.) June 13 - 1870
8. AGE: Years 78 | Months 2 | Days 8 | If less than one day hr. min
9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name J Howard Kemp
13. Birthplace Md

MOTHER
14. Maiden Name Susan Annacent
15. Birthplace Md

16 (a) Informant: J Best Cole
(b) Address Hampstead Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 24/48 (month) (day) (year)
(c) Cemetery or crematory Grace Methodist
Location Baltimore Md

18 (a) Funeral director Edw A Piper
(b) Address Hampstead Md

19 (b) 1948 (Date rec'd by registrar)

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1948, at 9.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948, to August 21 1948, and that I last saw her alive on August 21 1948.

Immediate cause of death: Senility — Duration 10 yrs

Due to

Due to

Other Conditions Senile dementia 2 yrs
hypertension
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin N. Borden M. D.
Address 2030 W. Fayette St Date signed 8/22/48

162a

G66070

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66070 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 Fawn. St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 907 Fawn St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sebastian Valenti

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Josephine Masumeci

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 1882

8. AGE: Years 66 | Months 3 | Days 19 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Rosario Valenti
13. Birthplace Italy

MOTHER
14. Maiden Name Ignazia ?
15. Birthplace Italy

16 (a) Informant Charles Valenti (Son)
(b) Address 907 Fawn St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. & Moravia Ave.

18 (a) Funeral director Frank Pelligrini
(b) Address 322 S. High St.

AUG 22 1948 (Date rec'd by reg.) (b) Registrar Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 19 48 at 1 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 10 19 48 to Aug 20 19 48
and that I last saw h alive on Aug 20 19 48

Immediate cause of death Ruptured
aneurysm of Brain.

Duration 10 days

Due to Hypertension &
Arteriosclerosis -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1 Mid Cath St Baltimore Md. Date signed Aug 21 - 48

correct age is especially important. Physicians: please write the cause of death clearly and

66071

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 1170

G66071
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard and Madison Aves.
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. ~~(yrs., mos., or days)~~ 2
(e) Length of stay in Baltimore ~~(yrs., mos., or days)~~ 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town White Hall (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 34 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Joseph Canova

3 (b) If veteran, name war none
3 (c) Social Security Account No. 216-07-5733

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M.

6 (b) Name of husband or wife Ethel Jane Canova
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1904

8. AGE: Years	Months	Days	If less than one day
43	10	6	— hr. — min.

9. Birthplace Philadelphia, Penna. (Town, county, and state)
10. Usual Occupation Skilled Laborer
11. Industry or business Private Contractor

FATHER
12. Name Anthony Canova
13. Birthplace Naples, Italy

MOTHER
14. Maiden Name Christina Pozzi
15. Birthplace Naples, Italy

16 (a) Informant Ethel Jane Canova
(b) Address White Hall, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 26, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's Cemetery
Location Texas, Balto. Co., Md.

18 (a) Funeral director Jacob Hartenstein
(b) Address Peter Freedom, Pa.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Registrar [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-23 1948 at 1.25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1948 to 8-23 1948 and that I last saw him alive on 8-23 1948

Immediate cause of death	Duration
Cardio-Pulmonary Failure	
Due to Shock, Hemorrhagic, acute	
Due to Gastric Ulcer	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death.)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature W. K. Bruden M. D.
Address Md. Gen. Hosp. Date signed 8-23-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46 E

Registered No. G66072

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Use no abbreviations. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Schapiro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1915

8. AGE: Years	Months	Days	If less than one day
33	6	5	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Jacob Mopsikov
13. Birthplace Russia

MOTHER
14. Maiden Name Birdie Lavenstein
15. Birthplace Russia

16 (a) Informant Abraham Schapiro
(b) Address 3820 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)
(c) Cemetery or crematory Mickro Kodesh
Location Bowleys Lane, Herring Run

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1124-26 W. North Ave

19 AUG 23 1948 (Date rec'd by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1948, at 11:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1948 to Aug 22 1948 and that I last saw h[illegible] alive on Aug 22 1948

Immediate cause of death Cardiac respiratory - renal failure

Due to Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allan A. Marks M. D.
Address Sinai Hosp Date signed 8/23/48

VS 150

C66073

3C - 48-16715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a

Registered No. C66073

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 IRVINE PLACE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANDREA PARSLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	WHITE	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-21-48

8. AGE— Years | Months | Days: 20 | If less than one day: hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business

FATHER
12. Name Leon Parsley
13. Birthplace W. Va.

MOTHER
14. Maiden Name JUNE EASTHAM
15. Birthplace KENTUCKY

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, ~~cremation~~, removal) (b) Date thereof 8/23/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Glen Haven
Location Glenburnie Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1948 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1948 to 8-21 1948, and that I last saw her alive on 8-21 1948.

Immediate cause of death: Pneumonia
Due to: Acute Infantile Diarrhea
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type if fatal)
(e) Means of injury

23. Signature Milton Markwell MD M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G66074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G66074

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Avenue
(c) Hospital or institution: Edgewood Nursing Home 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3750 Old York Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NETTIE C. BARTHOLOMAEI

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Albert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1880

8. AGE: Years	Months	Days	If less than one day
67	10	22	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Frank L. Colling
13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret Hobbs
15. Birthplace Maryland

16 (a) Informant Mrs. Nathe Turner
(b) Address 3750 Old York Road

17 (a) Burial (b) Date thereof Aug. 25, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) AUG 23 1948 (b) Huntington Williamsburg
(Date rec'd by registrar)

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1948, at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to 8-22 1948.
and that I last saw h.[illegible] alive on 8-21 1948.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to	
Due to	
Other Conditions Senility	
Chronic Nephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. L. Everett M.D.
Address 36 York Ct. Date signed 8/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered; if unknown, state so. Be sure that correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1479

Registered No. G66075

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3523 Lucile Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3523 Lucile Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred L Petersen

3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-01-4817

4. Sex Mal
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Christina
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 24 1883
8. AGE: Years 64 Months 7 Days 27 If less than one day hr. min.
9. Birthplace Denmark (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Empire Const Co

FATHER
12. Name Martin Petersen
13. Birthplace Denmark

MOTHER
14. Maiden Name Christine Johnson
15. Birthplace Denmark

16 (a) Informant Mrs Thyra Petersen
(b) Address Randalstown Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 24 48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md
18 (a) Funeral director Wilson Co Inc
(b) Address 1300 E Fort Ave
19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1948, at 6 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1948 to Aug 21 1948, and that I last saw him alive on Aug 21 1948.

Immediate cause of death Carcinoma of Lung — Duration 5 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Manuel Lewis M. D.
Address 3818 Reisterstown Rd Date signed Aug 24 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Write plainly. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

66076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 66076

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. Use "None" where necessary. If unknown, or if the question is not applicable, leave blank. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3202 Overland Ave
(c) Hospital or institution: 27
(d) Length of stay in hospital or inst. (yrs., mos. or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3202 Overland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George J. Blomeier.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minnie Blomeier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 10th 1875

8. AGE: Years	Months	Days	If less than one day
73	6	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Coal & Oil merchant.
11. Industry or business Retired

FATHER
12. Name Ernest Blomeier.
13. Birthplace Germany

MOTHER
14. Maiden Name Friederich Hille
15. Birthplace Germany

16 (a) Informant Mrs Minnie Blomeier
(b) Address 3202 Overland Ave

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof Aug 23 (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Burial

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20th 1948 at 7 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to Aug 20 1948, and that I last saw him alive on Aug 20 1948.

Immediate cause of death Chronic myocarditis — Duration 20 yr

Due to Severe arteriosclerosis

Due to Hypertension

Other Conditions Dry gangrene feet

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold M.D.
Address 4706 Hayford Road State signed 8/24/48

VS 150

66077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 66077

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2636 Frederick ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2636 Frederick ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Pitzinger

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-9245

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Bessie L. Pitzinger
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr) Aug 18, 1884

8. AGE: Years	Months	Days	If less than one day
64	0	3	hr. min.

9. Birthplace Talbridge (Town, county, and state) Md.
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name John W. Pitzinger
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Margaret Seward
15 Birthplace Maryland

16 (a) Informant Mrs Bessie L. Pitzinger
(b) Address 2636 Frederick ave Balto. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24 1948 (month) (day) (year)
(c) Cemetery or crematory Melville Cemetery
Location Talbridge Md.

18 (a) Funeral director S. Lester Earle
(b) Address 503 Main St. Talbridge, Md.

19 (a) AUG 23 1948 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 19 48 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 19 48 to Aug 21 19 48 and that I last saw h[illegible] alive on Aug 21 19 48

Immediate cause of death Carcinoma of stomach

Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert H. Yates
Address 2034 Walbrook Ave Date signed 8/24/48 M.

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Please see that the information as to correct age is especially important.

VS 150

66078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G66078

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5404 Purlington Way
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 1yr. 3[illegible]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5404 Purlington Way (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Mary Elizabeth Kinney

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband/wife ##### Michael H. Kinney
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years	Months	Days	If less than one day
About 75	---	---	--- hr. --- min.

9. Birthplace Girard, Ohio (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Edward H. O'Neill
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Kelly
15. Birthplace Ireland

16 (a) Informant Mrs. Norene K. Lewis
(b) Address 5404 Purlington Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery ###### New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. A. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Huntington Nellingsmith Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/22 1948 to 8/22 1948 and that I last saw him alive on 8/22 1948

Immediate cause of death	Duration
Cerebral apoplexy	
Due to Hypertensive cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. O'Neill M.D.
Address 240 N Purlington Date signed 8/24/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66079

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital - Balto Md. (If not in hospital or institution, give street address or location)
(d) Length of stay in hospital or institution (yrs., mos., or days) 1 yr 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr 5 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Cumberland Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Patricks Church (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Ireland

3 (a) FULL NAME: Rt. Rev. James I. Quinn, V. F.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age yrs.
7. Birth date of deceased (mo., day, yr.) Nov 11, 1875
8. AGE: Years 72 Months 9 Days 0 If less than one day hr. min.
9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Priest
11. Industry or business

INFORMANT OR FATHER
12. Name William Quinn
12. Residence Ireland
14. Maiden Name Catherine Kelly
15. Birthplace Ireland
16 (a) Informant Rev. Chas. B. Bergen Rect. 1 Mt. Saint St. Cumberland Md.

16 (b) Date thereof 8/25/48 (month) (day) (year)
16 (c) Cause
Location Cumberland, Md.
13 (a) Funeral director E. H. Mann & Son
(b) Address 805 N. Calvert St.
19 AUG 23 1948 (Date rec'd by registrar) (b) Baltimore, Md. Registrar
VS 150 Via Automobile Hearse

PLEASE WRITE IN INK WITH UNFADING INK. Every item of information should be entered. Be sure correct age is entered. Physicians: please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1948 at 8:20 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1947 to 8/20 1948 and that I last saw him alive on 8/20 1948.
Immediate cause of death Cardiac failure
Interventricular Cl
Due to Coronary
Due to Diabetes Chronic decompensation
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Nil
Major findings of operation:
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. J. Venable for MD M. D.
Address St Agnes Hospital Date signed 8/24/48

G66080

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G66080 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lutheran Hospital 23 +d
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town 168 W. Cross (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT 12034 COSTON

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-0943

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 3. 1903

8. AGE: Years	Months	Days	If less than one day
44	8	17	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER	12. Name	Horace Coston
	13. Birthplace	Va
MOTHER	14. Maiden Name	Annie Rice
	15. Birthplace	md

16 (a) Informant Annie Coston
(b) Address 1814 Edmondson ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24 43 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Stagg
(b) Address 142 W. Fayette St

19. AUG 23 1943 Huntington Williams, Registrar
(Date Accepted by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1943, at 2 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23 1943, to 8-20 1943, and that I last saw h alive on 8-20 1943.

Immediate cause of death	Duration
(a) Pulmonary edema	
INTRA	
Due to (b) Intracerebral hemorrhage - left	
Due to (c) Hypertensive cardio-vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8-24-43

Major findings of operation: Intracerebral hemorrhage - left

If autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signeture W. Edward Goldsborough M. D.
Address Lutheran Hosp Date signed 8-21-43

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and report correct age is especially important.

8081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83a

Registered No. 666081

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate before it is filed. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 27 N Carey St

(c) Hospital or institution: Good Samaritan Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 846 N Fayette St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George N Hellmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2 1873

8. AGE: Years 75 Months Days 19 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Henry Hellmann

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Lydia Scheit

15. Birthplace Baltimore Md

16 (a) Informant Mrs Mary E Flook

(b) Address 2723 Englewood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Balto. Co. Md.

18 (a) Funeral director Wilson Colvin Inc

(b) Address 1517 E Fort Ave

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1948 to Aug 20 1948 and that I last saw him alive on Aug 20 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 days

Due to: Hypertension — 2

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry Shipsman M. D.

Address 753 N Patterson Park Ave Date signed Aug 22 1948

V S 150

66082

HEALTH DEPARTMENT—CITY OF BALTIMORE 66082

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH
~~CITY OF BALTIMORE~~: (No. 309 E 22ND ST. St., Ward)

Registered No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME ARTHUR MITCHELL MORROW

(a) Residence: No. 309 E 22ND St., 12-4 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

3a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) SEPT 9, 1874

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
73	11	13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. MACHINIST

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) ANDERSONBURG
(State or country) PENNSYLVANIA

FATHER

13. NAME RICHARD MORROW

14. BIRTHPLACE (city or town) PENNSYLVANIA
(State or country)

MOTHER

15. MAIDEN NAME SARA HOHENSHILT

16. BIRTHPLACE (city or town) PENNSYLVANIA
(State or country)

17. INFORMANT MRS VYRTA HATFIELD
(Address) 309 E 22ND ST

18. BURIAL, CREMATION, OR REMOVAL
Place MEADOWRIDGE Date AUG 24 1948

19. UNDERTAKER WM. COOK INC.
(Address) 1217 ST PAUL ST. Huntington Valley, Md.

20. FILED AUG 23 1948 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 22, 1948

22. I HEREBY CERTIFY, That I attended deceased from July 10, 1948, to Aug 22, 1948
I last saw alive on Aug 21, 1948. Death is said to have occurred on the date stated above, at 4 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	
Paralysis	7/1/48
Arteriosclerosis	10 yrs
Anorexia	2 days

Other contributory causes of importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ✓ Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) Chas. A. Greenemeyer M. D.

(Address) 2458 Harford Rd

X

state CAUSE OF DEATH in this space, in terms of disease and modes of violence. OCCUPATION is very important. See instructions on back of certificate.

66083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

✓ G66083
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. Where there is no correct answer, write "None" or "Unknown" as the case may be. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Aves
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2230 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Stone

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, ~~widowed, or~~ divorced: Married

6 (b) Name of husband or wife: Dora Weinman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1885

8. AGE: Years 63 | Months 3 | Days 23 | If less than one day: hr. min. 2

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER 12. Name Henry M. Stone
13. Birthplace Russia

MOTHER 14. Maiden Name Hannah B. Cabrinsky
15. Birthplace Russia

16 (a) Informant Mrs. Dora Stone
(b) Address 2230 Garrison Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)
(c) Cemetery or crematory Har Zion Cem
Location Rosedale

18 (a) Funeral director Sol Gelman & Bro
(b) Address 1124-26 W North Ave

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1948, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22, 1948 to Aug 23, 1948, and that I last saw h alive on Aug 23, 1948.

	Duration
Immediate cause of death Bronchopneumonia	
Due to Uremia	
Due to Arteriosclerotic glomerulonephritis	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy not yet reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address Sinai Hosp. Date signed 8-23-48 M. D.

VS 150

1318

G66084
AB-122114

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66084
Registered No.

186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Holly Neck Grill-RFD #3 Box 336 B
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Logan Bernard -or George Logan Barnard

3 (b) If veteran, name war

3 (c) Social Security Account No. 315-14-0220

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 1-1902 May 31-1903-or

8. AGE: Years 45? or Months 3 Days 19 If less than one day hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name George Bernard
13. Birthplace Kentucky

MOTHER
14. Maiden Name Ruth Hitchock
15. Birthplace Kentucky

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-24-48 (month) (day) (year)

(c) Cemetery or crematory
Location Evergreen Glade

18 (a) Funeral director J. Bruchenthe
(b) Address 1487 Eastlake Ave Rd Hamilton for Williams, MD

19 (a) AUG 23 1948 (b) (Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20- 1948 at 6.40 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 8-14 1948 to 8-20 1948 and that I last saw him alive on 8-20- 1948

Immediate cause of death: Sub. dural hematoma, acute, r t side
Due to: trauma
Due to:
Other Conditions: Bronchopneumonia, Pulmonary edema.
(Include pregnancy within 3 months of death)
Date of operation 8.14.48
Major findings of operation: Sub-dural hematoma
of autopsy: Same

Duration: 2 hrs? 1 wk

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Unknown Acc?
(b) Date of occurrence 8.14.48? at 10 00 AM
(c) Where did injury occur? Baltimore Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell from ladder

23. Signature [illegible]
Address 4940 Eastern Ave Date signed 8-21-48 M. D.

CERTIFICATE TO BE APPROVED BY THE MEDICAL EXAMINER
Dr. H. T. B. McCadden, per Thomas J. Mackin, M.D.

VS 153

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G66085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66085

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 556 Longwood ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-7
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 556 Longwood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Wiener

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-8-97

8. AGE: Years 51 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Russia

MOTHER
14. Maiden Name Diana
15. Birthplace Russia

16 (a) Informant Lena Wiener
(b) Address 556 Longwood ave

17 (a) Disposal (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Rawn Inc.
(b) Address 2100 Eutaw Place

19 AUG 23 1948 (Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22 1948 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1947 to 8/22 1948, and that I last saw him alive on 8/22 1948

Immediate cause of death: Coronary Thrombosis — Duration: 1 day

Due to

Due to

Other Conditions Coronary Artery Dis — 17 mo

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward A. Kallins, M.D.
Address 1847 W. North Ave Date signed 8/23/48

VS 150

X

86086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 86086

PLEASE WRITE PLAINLY, WITH UNFADING INK. Either type or print. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3500 DENNLYN RD
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 DENNLYN RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT LIBOWITZ

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife 109

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1889

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace BALTO. MD (Town, county, and state)

10. Usual Occupation MERCHANT

11. Industry or business

FATHER
12. Name NATHAN LIBOWITZ
13. Birthplace RUSSIA

MOTHER
14. Maiden Name ROSE
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)
(c) Cemetery or crematory BALTO HEBREW
Location BELAIR RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW PLACE

19 (a) AUG 23 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 22 1948, at 7:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1939 to Aug. 22, 1948, and that I last saw him alive on Aug. 20, 1948.

Immediate cause of death arteriosclerotic cardio-vascular disease with hypertension — Duration 10 years

Due to

Due to

Other Conditions Uremia — 6 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. A. Thooman M. D.
Address 1109 N. Calvert St Date signed 8/23/48

VS 150

66087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 M

Registered No. 66087

PLEASE WRITE PLAINLY, WITH UNFADING INK. Insert correct age in years if known. Answer every question. Where the word "None" should be used, do not use a dash. Where unknown, or not applicable, write word. Do not abbreviate. Use ditto marks sparingly. Be sure that the cause of death is stated so as to show the primary cause, secondary, and contributory causes, if any, and the duration of each. Do not report the mode of dying, such as heart failure, asthenia, etc., alone. Indefinite and unsatisfactory causes of death will be returned for correction. Be sure that the cause of death is clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1737 E. Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Levin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Eva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
67	4		hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Charles Levin
(b) Address 1737 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 200 Eutaw Place

19 (a) (b) Washington, D.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 22, 1948 at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 15, 1948 to AUG 22, 1948 and that I last saw HIM alive on AUG 22, 1948.

	Duration
Immediate cause of death Cardio-respiratory failure	
Due to Uremia	
Due to Poss neplurectomy Prostate urinary tract neoplasm	
Other Conditions Poss CA prostate & liver metastasis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irvin M. Cushner
Address Sinai Hospital Date signed 8-22-48

V8 150

131a

66088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G66088

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3602 FOSTER AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 FOSTER AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES J. TRAGER

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife ELIZABETH TRAGER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) JUNE 11, 1873

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75	2	9		

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name ? TRAGER
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN.
15. Birthplace GERMANY.

16 (a) Informant CHARLES J. TRAGER JR.
(b) Address 3602 FOSTER AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-23-48. (month) (day) (year)
(c) Cemetery or crematory 1ST UN. EVANGELICAL
Location O'DONNELL ST.

18 (a) Funeral director Charles J. Zeiler
(b) Address 901 S. CONKLING ST.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 20, 1948 at 4 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Aug 20 1948
and that I last saw him alive on Aug 20 1948.

Immediate cause of death Coronary Thrombosis — Duration 2 wks

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Gaskal M. D.
Address 630 S. Conkling St. Date signed 8-21-48

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

66089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 ✓

Registered No. C66089

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hrs and 40 mins
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1717 N. Rear Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

2 (c) FULL NAME William Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Hattie Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1897

8. AGE: Years 50 | Months 8 | Days 9 11 | If less than one day hr. min.

9. Birthplace Bark River, Md (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name William Smith Sr.
13. Birthplace Barkriver, Md

MOTHER
14. Maiden Name Don't know
15. Birthplace

16 (a) Informant Hospital records
(b) Address None

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25 1948 (month, day, year)
(c) Cemetery or crematory Lincoln Mem Park
Location Cheverly Md

18 (a) Funeral director Wm. George A. Fuller
(b) Address 1632 Druid Hill Ave

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Filed Aug 25 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-21 1948 at 10 25/A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1948 to 8-21 1948, and that I last saw him alive on 8-21 1948.

	Duration
Immediate cause of death: Pulmonary Edema 12 hrs	12 hrs
Due to: Cardiac decompensation	48 hrs
Due to:	
Other Conditions: Diabetes mellitus - duration - unknown	unknown

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joana D. Carr M. D.
Address 515 Marlboro St Date signed 8-24-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be filled in. Fill in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

95c

66090 Bal 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G66090 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Ethering St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thornton Gillis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Clementine

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) 6-12-88

8. AGE: Years 60 | Months 2 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER 12. Name Henry Gillis

13. Birthplace Virginia

MOTHER 14. Maiden Name Sarah Matthews

15. Birthplace Virginia

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 24, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Geo. W. Holland

(b) Address 1625 Druid Hill Ave.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Buried in Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20 1948, at 7:25 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12- 1948 to 8-20 1948, and that I last saw him alive on 8-20 1948.

Immediate cause of death: Carcinoma of Lung — Duration: 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy Carcinoma of Lung

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard S Ross, M.D.
Address JOHNS HOPKINS HOSPITAL Date signed 8/20/48

VS 150

correct age is especially important. Physicians, please write plainly.

6091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66091

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Provident Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2030 Pulaski Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ruth Garnes (GARNES)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clyde

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1898

8. AGE: Years 50 | Months 1 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name James Parks

13. Birthplace Balto. Co. Md.

MOTHER 14. Maiden Name Mary Simpson

15. Birthplace Balto. Co. Md.

16 (a) Informant Mr. Clyde Garnes

(b) Address 2030 Pulaski Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 22, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Cooper & Sons

(b) Address 1409 Druid Hill Ave.

19 (a) AUG 23 1948 (Date rec'd by City Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20 1948, at 7:57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1948 to 8/20 1948 and that I last saw h alive on 8/20 1948.

	Duration
Immediate cause of death: Uremia	
Due to: Hypertensive C-V Renal Disease	4 days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Preston Grant M.D.

Address 640 N. Carrollton Date signed 8/21/48

66092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G66092

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 23st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1253 Broadway (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Rudolph Broring

3 (b) If veteran, name war WW I

3 (c) Social Security Account No. 215-05-0907

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jun 21, 1886

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	2	0		

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Bernard H. Broring
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Taylor
15 Birthplace Germany

16 (a) Informant Records
(b) Address U.S. Marine Hosp., Balto., Md.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 8/24/48 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto. G. 9 Plot

18 (a) Funeral director C. J. Tamburro & Son
(b) Address 1938 E. Lafayette Ave.

19 AUG 23 1948 (Date rec'd by registrar) **(b)** Contingent Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 19 48 at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 19 48 to Aug 21 19 48. and that I last saw him alive on Aug 21 19 48.

Immediate cause of death Thrombosis, Basilar artery — Duration 1 day

Due to Arteriosclerosis, gen. — unknown

Due to Hypertensive cardiovascular disease — 8 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Robert E. Miller
Address US Marine Hosp. **Date signed** 8/21/48 M. D.

Correct age is especially important

VS 150

G66093

TIGNALL

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G66093

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Rosedale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret M. Tignall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	married

6 (b) Name of husband or wife Charles Tignall
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1881

8. AGE: Years	Months	Days	If less than one day
66	11		hr. min.

9. Birthplace Baltimore Md. (Town, county, and State)
10. Usual Occupation House wife
11. Industry or business at Home

FATHER
12. Name Edward Griffin
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McEnaney
15. Birthplace Ireland

16 (a) Informant Mrs Charles J. Tignall
(b) Address 1602 Rosedale St.

17 (a) buriel (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Bowen Son
(b) Address 901-03 Wollins St.

19 AUG 23 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20 1948, at 3 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 1948, to 8-20 1948, and that I last saw her alive on 8-20 1948

Immediate cause of death	Duration
Cardio Respiratory failure	
Due to Coronary Thrombosis	1 wk.
Due to	
Other Conditions Diabetes Mellitus Dehydration Nephrosis, Generalized Arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Coronary Sclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Joseph LiPuma D
Address Mercy Date signed 8/20/48

94a

VS 190

correct age is especially important. Physicians: please write the cause of death plainly.

G66094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G66094

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made in permanent ink. Use no abbreviations. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3023 Pinewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore -14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3023 Pinewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THEODATE FRANCIS

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife: Marion A. Francis
6 (c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.) Aug. 18. 1878

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70	0	3		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward A. Knott
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Towson
15. Birthplace Maryland

16 (a) Informant Mr. Marion A. Francis Sr.
(b) Address 3023 Pinewood Ave. - 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 24. 194 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address Baltimore Md.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Lexington for Allegany Mar

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21. 1948 at 12.35P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1946 to Aug. 21, 1948. and that I last saw him alive on Aug 20, 1948.

Immediate cause of death: Coronary Thrombosis — Duration

Due to Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel D. Wolfe M. D.
Address 1331 E. Monument Ave Date signed 8-21-48.

66095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66095

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3240 E. Lombard St., Balto.-24
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lina Resch

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe.	white	married

6 (b) Name of husband or wife George M. Resch Sr.
6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr) January 30, 1868

8. AGE: Years	Months	Days	If less than one day
80	6	20	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Wife
11. Industry or business Home

FATHER
12. Name George M. Rohrig
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Morris
15. Birthplace Baltimore Md

16 (a) Informant Mr. Frederick H. Resch (Son)
(b) Address 2930 Edison Highway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23. 1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address Baltimore Md.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Cemetery for Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20-48 19 . at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5/ 19 48, to 8/20/ 19 48.
and that I last saw her alive on 8/20/ 19 48.

Immediate cause of death Broncho - Pneumonia

Due to Arteriosclerotic Heart Disease

Due to Hypertension - Cardiovascular Disease

Other Conditions Myocardial Insufficiency

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Ray E Resch Jr. M.D.
Address 1. Joseph Hosp. Date signed 8/20/48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

66096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. 66096

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2808 Rosalie Ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (14)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Rosalie Ave.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Edwin T. Burke

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-05-3459

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Viola Burke (nee Boorey)

6 (c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.) July 2 1894

8. AGE: Years 54 | Months 1 | Days 18 | If less than one day: hr. min.

9. Birthplace (Town, county, and state) Baltimore Md.

10. Usual Occupation Painter

11. Industry or business B. & O. R.R.

FATHER
12. Name John Burke
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Fate (?)
15. Birthplace Balto Md.

16 (a) Informant Mrs. Viola Burke (Wife)
(b) Address 2808 Rosalie Ave Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23 1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood Mem. Park
Location Parkville, Md.

18 (a) Funeral director C. Bowers Evans
(b) Address 1400 Charles St. Balto 39 Md.

AUG 23 1948 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Fri., Aug. 20, 1948, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948 to Aug 20 1948 and that I last saw him alive on July 29 1948 (8/19/48)

Immediate cause of death: Bronchial Pneumonia.

Due to —

Due to —

Other Conditions: Mitral Regurgitation Hypertension

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

Duration

—

—

—

G66097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66097

83a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 522 S Caroline St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 522 S Caroline St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Annie Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 27 1891

8. AGE: Years	Months	Days	If less than one day
57	4	24	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Domesitc

11. Industry or business

FATHER
12. Name Edward Taylor
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie Banks
15. Birthplace Dorchester Co. Md.

16 (a) Informant Margret Johnson
(b) Address 522 S. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 23. 48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvery. Cem.
Location Brookly Md.

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantly

19 (a) (Date rec'd by registrar) AUG 23 1948

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1948, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1948. to Aug 20 1948
and that I last saw her alive on Aug 20 1948.

Immediate cause of death: Pulmonary edema
Cardiac Failure
Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 days
1 day
10 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Wm L. Berry M. D.

Address 1420 E. Chase Date signed Aug 23. 48

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Statement of age is especially important.

G66098

IB 121682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

98

Registered No. G66098

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Balto. City Hospitals

8-16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1Mo.9days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1614 N. Durham St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John C. Maasch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Margaret A. Sparr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 20, 1879

8. AGE: Years	Months	Days	If less than one day
68	9	1	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Ernest Marsh

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Youngk

MOTHER 15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 Broadway.

19 (a) AUG 23 1948 (Date received) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-21 19 48 at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 19 48 to 8-21 19 48 and that I last saw him alive on 8-21 19 48

Immediate cause of death Bronchopneumonia — Duration 4 days

Due to

Due to

Other Conditions arteriosclerotic gangrene of leg left (Include pregnancy within three months of death)

Date of operation 8/14/48

Major findings of operation: gangrene of leg

of autopsy: ✓

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Gordon Craft M.D.

Address Balt. City Hosp. Date signed 8/21/48

correct age is especially important. Physicians: please write the cause of death

VS 153

107

G66099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G66099 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 75 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 EDMONDSON AV., #23 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT BRYAN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: RACHEL BRYAN
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr): APRIL 6, 1873
8. AGE: Years 75 | Months 4 | Days 15 | If less than one day: hr. min.
9. Birthplace: MARYLAND (Town, county, and state)
10. Usual Occupation: COOK
11. Industry or business

FATHER
12. Name: UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace

16 (a) Informant: RACHEL BRYAN
(b) Address: 1527 EDMONDSON AV. #23

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory: Antietam
Location: Balto Co

18 (a) Funeral director: Wm. A. Jackson
(b) Address: 916 Penna. Ave

19 (a) AUG 23 1948 (Date received by Registrar) (b) Huntington Williams, Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUGUST 21, 1948, at 12.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 18, 1948. to AUG. 21, 1948. and that I last saw him alive on AUG. 21, 1948

Immediate cause of death: CARDIAC FAILURE; INTESTINAL OBSTRUCTION — Duration: UNDETERMINED 6 HRS.
Due to: INCISIONAL AND INGUINAL HERNIAS — Duration: 3 YRS.
Due to: — Duration: UNDETERMINED PROBABLY CONGENITAL
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation: NONE
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: M. Samuel A. Harris, M.D.
Address: 1 Med. Chir. Hosp. Date signed: 8/21/48

X

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I hereby certify that the above is a correct and true copy of the original certificate filed in the Bureau of Vital Statistics, Baltimore City Health Department. Physicians: please write the causes of death clearly and legibly. Underlining of the correct age is especially important.

66100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G66100 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 Wilmer Court
(c) Hospital or institution:
17+2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(c) Street No. 1122 Wilmer Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZA DELOWITCH) ELiza Delbridge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Jackson, North Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Miles Sykes
13. Birthplace North Carolina

MOTHER 14. Maiden Name Cherry Ann ?
15. Birthplace North Carolina

16 (a) Informant David Delbridge
(b) Address 1122 Wilmer Court

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 8-25-48 (month) (day) (year)

(c) Cemetery or crematory Fork.
Location Weldon, N. C.

18 (a) Funeral director Williams A. Jackson
(b) Address 916 Penna. Ave.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Huntington, West Virginia, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22/48 19 , at 2:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Wears M.D.
Medical Examiner.
Date signed 8/22/48

VS 151

Please write correct age is especially important. Physicians: please write the causes of death clearly, and be sure

G66101

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30D

Registered No. G66101

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 540 W. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR BOWIE
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-17-1897
8. AGE: Years 50 Months 8 Days 3 If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charles Bowie
13. Birthplace Md.

MOTHER
14. Maiden Name Rhoda Scott
15. Birthplace Md.

16 (a) Informant Rhoda Bowie
(b) Address 540 - W. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-48 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cemetery.
Location

18 (a) Funeral director A. Halstead
(b) Address 916 Eutaw St

19 (a) AUG 23 1948 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1948, at 11.10 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Ruptured aortic aneurism, syphilitic

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallonee M.D.
Medical Examiner.
Date signed August 21, 1948

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

6102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66102

123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Avenues
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glen Haven Pasadena, Md. R.F.D.
(If outside city or town limits, write RURAL and give town)
(d) Street No. West Shore Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married.

6 (b) Name of husband or wife Lloyd Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/4/1895

8. AGE: Years	Months	Days	If less than one day
53	0	16	hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business OWN HOME.

FATHER
12. Name UNKNOWN - BURNS
13. Birthplace UNKNOWN.

MOTHER
14. Maiden Name UNKNOWN.
15. Birthplace UNKNOWN.

16 (a) Informant MR. LLOYD SMITH.
(b) Address WEST SHORE RD. Glen Haven Pasadena Md.

17 (a) BURIAL (b) Date thereof Aug. 24, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location GLEN BURNIE, Md

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19. 8 23 1948 Thomas Williams Jr. Registrar
(Date rec'd by registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1948, at 11:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1948 to 8/20 1948, and that I last saw h[er] alive on 8/20 1948.

Immediate cause of death Cardiac failure -
Due to Severe shock
Due to Massive gastro-intestinal hemorrhage - cholecystectomy
Other Conditions
(Include pregnancy within 3 months of death)

Duration
..

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. J. Kenath L. M.D.
M. D.
Address St. Agnes Hospital Date signed 8/24/48

PLEASE WRITE correct age is especially important. Physicians: please write the causes of death clearly, as

66103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 929

Registered No. 66103

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 722 Cumberland St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 Cumberland St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Eliza

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr) Nov. 1, 1856

8. AGE: Years	Months	Days	If less than one day
91 92	9	20	hr. min.

9. Birthplace St. Mary's County, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Eliza Butler
(b) Address 722 Cumberland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Arbutus, Md.

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 Woodlloh Street

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Huntington Woods Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1948, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to Aug 21 1948 and that I last saw h alive on Aug 21 1948

Duration
Immediate cause of death Cardio Vascular Disease	2 yrs
Due to Workmen Compensation	3 mo's
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William Frey
Address 1928 Penna Ave Date signed 8/23/48

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

66104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

Registered No. G66104

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette & Calhoun St.

(c) Hospital or institution: 271 Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2908 Louise Ave. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Heimbuch, George F. Heimbach

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-24-0565

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Regina I. Heimbuch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 1. 1888

8. AGE: Years 59 | Months 10 | Days 20 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None Printer

11. Industry or business —

FATHER 12. Name John Heimbuch

13. Birthplace Md

MOTHER 14. Maiden Name Denah Direhner

15. Birthplace Md

16 (a) Informant Mrs. Regina I. Heimbuch

(b) Address 2908 Louise ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cemetery

Location Eastern ave

18 (a) Funeral director Howard N. Bligh Jr.

(b) Address 6803 Harford Road

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1948 at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1948 to 8/21 1948 and that I last saw h[illegible] alive on 8/21 1948.

Immediate cause of death Uremia — Duration

Due to Obstruction & Generalized Metastasis

Due to Cancer of the Bladder.

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation Cancer of Bladder

Major findings of operation: Sept 8, 1947

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Michael R. Ravenel M.D.

Address 7 Rich Lg Hosp Date signed 3-30-49

correct age is especially important. Physicians: please write the cause of death plainly.

VS 153

66105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. 66105

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Parksley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Otto Kniepert

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-09-0511

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Margarete Kniepert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1883

8. AGE: Years 64 | Months 11 | Days 4 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business U. S. Lithograph Co.

FATHER
12. Name Fritz
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Busse
15. Birthplace Germany

16 (a) Informant Mrs. Margarete Kniepert
(b) Address 407 Parksley Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory Ft. Lincoln Cem.
Location Wash., D. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 23 1948 (Date rec'd by registrar) (b) Lumberton Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Aug 1948 at 6:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Cerebral Concussion

Other Conditions Generalized Arteriosclerosis - Fresh Ankle Fracture
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 15 Aug 48
(b) Where did injury occur? Richmond-Lombard
(c) Did injury occur at home, on farm, industrial place, in public place? Public (Specify whether at work) W.
(d) Means of injury Struck by auto

23. Signature Earl L. Koons M.D.
Medical Examiner.
Date signed 22 Aug 48

VS 131

PLEASE WRITE PLAINLY with pen or pencil. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G66106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G66106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not use abbreviations. Be sure to give correct age in each case. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3609 Reisterstown Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 12
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3609 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Grant Kettlewood

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ella H. Kettlewood

6 (c) If alive, give [illegible] years

7. Birth date of deceased (mo., day, yr.): Nov. 19, 1871

8. AGE: Years 76 | Months 9 | Days 2 | If less than one day: hr. min.

9. Birthplace: Glascow, Delaware (Town, county, and state)

10. Usual Occupation: Office Mgr.

11. Industry or business:

FATHER
12. Name: James Kettlewood
13. Birthplace: Delaware

MOTHER
14. Maiden Name: Mary Jane Martin
15. Birthplace: Delaware

16 (a) Informant: Mrs. Ella H. Kettlewood
(b) Address: 3609 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 AUG 22 1948 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1948, at 1045 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 7, 1948, to Aug. 21 1948, and that I last saw him alive on Aug. 20 1948.

Immediate cause of death: Myocardial Failure — Duration

Due to: Cardiac Asthma

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.
Address 520 Medical Arts Bldg. Date signed 8/23/48

66107
AB-122264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 66107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 21/2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1007 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Belle Clara Prendergast

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph Donald Prendergast

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 4-1907

8. AGE: Years: 41 Months: 2 Days: 8/7 If less than one day: hr. min.

9. Birthplace: Md. (Rising Sun)
(Town, county, and state)

10. Usual Occupation: Waitress

11. Industry or business: Waffle Inn

FATHER
12. Name: Simeon Alexander
13. Birthplace: Md. (Rising Sun)

MOTHER
14. Maiden Name: Minnie Krouse
15. Birthplace: Md. (Rising Sun)

16 (a) Informant: Baltimore City Hospitals-record
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/25/48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) AUG 23 1948 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22- 1948, at 11.25 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 8-20- 1948 to 8-22- 1948, and that I last saw her alive on 8-22- 1948

Immediate cause of death: Carcinomatosis — Duration: mos

Due to: Ca of colon — yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: 3 yrs ago

Major findings of operation: Ca of colon

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Gordon Craft M.D.

Address: Balto City Hosp Date signed: 8/22/48

Please write clearly with ink. Physicians: please write the cause of death correctly. Age is especially important.

VS 50

66108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 66108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Sinai Aged Home (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Pollock

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1864

8. AGE: Years	Months	Days	If less than one day
84	6	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER'S MAIDEN NAME
12. Name Mrs. Pollock,
13. Birthplace Germany.

FATHER'S NAME
14. Maiden Name Amelia Schloss,
15. Birthplace Germany.

16 (a) Informant Mrs. Lee Rascover,
(b) Address 2301 Carlton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Sonnheim & Sons
(b) Address 2027 Eutaw Place

19 (a) AUG 23 1948 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1948, at 11:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1948 to Aug. 22, 1948, and that I last saw her alive on Aug. 22, 1948.

Immediate cause of death Arteriosclerosis — Duration

Due to

Due to

Other Conditions Duodenal Ulcer

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Sinai Hosp. Date signed 8-22-48

97

666109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

Registered No. 666109

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 S. Robinson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 S. Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Bachta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife Joseph F. Bachta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-12-1868

8. AGE: Years	Months	Days	If less than one day
80	7	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Dinberry
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Joseph F. Bachta
(b) Address 406 S. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director John A. Moran
(b) Address 3600 E. Balt. St.

19 (a) 8-23 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1948, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1948 to Aug 23 1948, and that I last saw h[illegible] alive on Aug 21 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 6 weeks

Due to: chr. arteriosclerosis — 2.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. J. Davidow M. D.
Address 3218 Eastern Date signed 8-23-48

correct age is especially important. Physicians: please write the exact

VS 130

66110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. G66110

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1916 E Fayette St 31
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt
(c) City or town Balt 31
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 E Fayette St 31
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Thomas McNulty

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-9321

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Julia McNulty
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) 16 Aug 72

8. AGE: Years	Months	Days	If less than one day
76	-	6	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Plumbing

FATHER
12. Name Martin McNulty
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget McNulty
15. Birthplace Ireland

16 (a) Informant Mrs. Julia McNulty
(b) Address 1916 E Fayette St 31

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John B. Moran
(b) Address 3006 E. Balt. St.

19 (a) [illegible] (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Aug 1948 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Aug 1948 to 22 Aug 1948 and that I last saw him alive on 22 Aug 1948.

Immediate cause of death

Due to Apoplexy Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2d.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2214 E Fayette St Date signed

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Be sure to fill in every item. Where there is no entry, write "None" or "Unknown" so that the record will not be incomplete. Be sure to give the correct age in each case. Physicians: please write the causes of death clearly and legibly. Be especially important.

VS 150

G66111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G66111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 7 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(c) City or town Baltimore (If outside city or town limits write RURAL and name town)
(d) Street No. 2603 Goodwood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Byer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Bessie B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 6 1894

8. AGE: Years 56 | Months 3 | Days 15 | If less than one day: hr. min

9. Birthplace: Balto Md. (Town, county, and state)

10. Usual Occupation: Steel Dye Engraver

11. Industry or business

FATHER
12. Name: Henry Byer
13. Birthplace: Md.

MOTHER
14. Maiden Name: Sophia Nickman
15. Birthplace: Md.

16 (a) Informant: Mrs. Bessie Byer
(b) Address: 2603 Goodwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Balto

18 (a) Funeral director: L. D. Luck
(b) Address: 5305 Stafford Rd.

19 (a) AUG 23 1948 (Date rec'd by registrar) (Transcription for Baltimore, Md.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 Aug 1948 at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed 23 Aug 48

VS 151

Please write in ink. Physicians: please write the causes of death clearly and legibly. Be sure your answers are complete and correct age is especially important.

6112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

Registered No. G66112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 7616 Bagley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Carville Hersch

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-9210

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ethel M. Nicholas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1 - 1898

8. AGE: Years	Months	Days	If less than one day
49	9	23	hr. min.

9. Birthplace Rock Hall Md. (Town, county, and state)
10. Usual Occupation Carpenter Empl.
11. Industry or business Edwards Co.

FATHER
12. Name John R. Hersch
13. Birthplace Md.

MOTHER
14. Maiden Name Emily Stevens
15. Birthplace Md.

16 (a) Informant Mrs Ethel M. Hersch
(b) Address 7616 Bagley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Baltimore, Md

18 (a) Funeral director Leonard J. Koch
(b) Address 5205 Harford Rd.

19 (a) AUG 23 1948 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1948, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1948 to Aug. 23 1948, and that I last saw him alive on Aug. 23 1948.

Immediate cause of death	Duration
Peripheral vascular collapse	
Due to Myocardial Infarction	
Due to Arteriosclerotic Coronary Artery Disease	2 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel L. Silverstein
Address Med Baltimore Hosp Date signed 8/23/48 M. D.

Huntington Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly.

6113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

S-66113 C663-3598 46E

Registered No. 25978

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 Bloom St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 Bloom St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Mitchell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	colored	(divorced)

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Housework

FATHER
12. Name James Wade
13. Birthplace Md

MOTHER
14. Maiden Name Ida Lippett
15. Birthplace Md

16 (a) Informant Ida Wade
(b) Address 530 Bloom St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Md

18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Eastman Ave

19 (a) AUG 23 1948 (Date received by Registrar) (b) Burlington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20- 1948, at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1- 1948 to 8-20- 1948.
and that I last saw her alive on 8-19- 1948.

Immediate cause of death
Carcinoma of intestines — Duration Unknown
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:-
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St. Date signed 8-21-48

VS 153

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

G66114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66114
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Read & Cathedral - Miller Hotel
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Read & Cathedral--Miller Hotel
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L. BARNETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13-1905

8. AGE: Years 43 | Months - | Days 10 | If less than one day hr. min.

9. Birthplace Wilmington Ohio
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Marion Barnett
13. Birthplace Ohio

MOTHER 14. Maiden Name Nellie Taylor
15. Birthplace Ohio

16 (a) Informant Roberts Funeral Home
(b) Address 921-S. Brown Street

17 (a) Removal (b) Date thereof Aug 23/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dayton
Location Ohio

18 (a) Funeral director William Cook Jr.
(b) Address 1217 E. Paul Street Huntington, W. Va.

1943 AUG 25
(Date rec'd by registrar)
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1943, at 5:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute dilatation of heart and acute edema of lungs

Due to

Other Conditions Chronic alcoholism
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D.
Medical Examiner.
Date signed 8-23-43

95c

PLEASE WRITE PLAINLY. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66115

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. 451 W. 24th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MILTON KAUFHERR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife Lillian

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) May-14-1917

8. AGE: Years	Months	Days	If less than one day: hr.	min.
31	3	9		

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Jewelry Salesman

11. Industry or business

FATHER 12. Name Maurice Kaufherr

13. Birthplace Germany

MOTHER 14. Maiden Name Thekla Heyman

15. Birthplace Germany

16 (a) Informant Mrs. Lillian Kaufherr

(b) Address 450 W. 24th St. New York

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 25-48 (month) (day) (year)

(c) Cemetery or crematory

Location New York

18 (a) Funeral director John E Connelly

(b) Address 416 Eastern Ave.

19 (a) AUG 24 1948 (Date rec'd by Registrar) (b) Burlington Wisconsin

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1948 at 2.30a M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hemorrhage from deep laceration of neck.

due to Fracture of jaw. Fracture left humerus.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-23-48 at 1.30 a. M.

(b) Where did injury occur? In front of Campbell Cement Co. Route 40 nr. Whitemarsh.

(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no

(d) Means of injury Two automobiles auto

23. Signature George G. Merrell M.D. Medical Examiner

Date signed August 23, 1948

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66116

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: Parkville, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2811 Garnet Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Alfred Dewin (Denn)

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No.: 215-07-7897

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife: Gertie May Denn
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 11th, 1897

8. AGE: Years	Months	Days	If less than one day
51		11	hr. min.

9. Birthplace: Frederick County, Md.
(Town, county, and state)

10. Usual Occupation: Electrician
11. Industry or business: Davison Chemical Co.

FATHER
12. Name: James C. Denn
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Elizabeth Chipley
15. Birthplace: Unknown

16 (a) Informant: Mrs. Alfred C. Denn
(b) Address: 2811 Garnet Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof: 8/25/48 (month) (day) (year)
(c) Cemetery or crematory: Glade Cemetery
Location: Walkersville, Md.

18 (a) Funeral director: Lanahan Funeral Home
(b) Address: 7401 Belair Rd.

19. AUG 24 1948 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 Aug 1948, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: Earl L. Voglyn M.D.
Medical Examiner
Date signed: 22 Aug 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66117

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Fullerton, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7543 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bruce M. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-6135

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Sena M. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12th, 1877

8. AGE: Years 71 | Months 6 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Boilermaker

11. Industry or business Spedden Ship Building

FATHER
12. Name David R. Smith
13. Birthplace Pa.

MOTHER
14. Maiden Name Rose McCarren
15. Birthplace Pa.

16. (a) Informant Mr. Robert Smith
(b) Address 7545 Belair Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/26/48 (month) (day) (year)
(c) Cemetery or crematory Fork Methodist
Location Fork, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7101 Belair Rd.

19 (a) AUG 24 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22 1948, at 10:25 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-Respiratory failure

Due to: Hypertensive Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D.
Medical Examiner.
Date signed 8-23-48

VS 151

correct age is especially important. Physicians: please write the cause of death plainly

6318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. G66118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132-N. Washington st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 132-N. Washington st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Gilmore Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-10-3275

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec-17-1889

8. AGE: Years	Months	Days	If less than one day hr.	min.
58 59	8	3		

9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Henry Gilmore Sr
13. Birthplace Baltimore - Md.

MOTHER
14. Maiden Name Harriet Jones
15. Birthplace Baltimore - Md.

16 (a) Informant Helen Roy (sister)
(b) Address 1421-E. Jefferson st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-24-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore, Md.

18 (a) Funeral director Holland Funeral Home
(b) Address 1631 - Druid Hill Ave.

19 AUG 24 1948 (Date rec'd by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1948. about 10:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to Aug 19 1948.
and that I last saw him alive on 19 Aug 1948.

Immediate cause of death	Duration
Respiratory aspiration	
Due to Bronchogenic Carcinoma	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. C. Burrell M.D.
Address 121 Aisquith St Date signed 8/23/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

6119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 666119

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1907 W. Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1907 W. Saratoga St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert O. Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1888

8. AGE: Years 60 | Months 2 | Days 17 | If less than one day: hrs. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Unknown Wood
13. Birthplace Unknown

MOTHER 14. Maiden Name Julia Stump
15. Birthplace Virginia

16 (a) Informant Rose V. Whitbeck
(b) Address 1907 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-48 (month, day, year)
(c) Cemetery or crematory Meadow Ridge
Location Washington Blvd.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 AUG 24 1948 (Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Aug. 1948, at 8:47 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular Renal Disease

Due to

Other Conditions Cerebral Vascular Accident, etc

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D.
Medical Examiner.
Date signed 23 Aug. 1948

correct age is especially important. Physicians: please write the cause of death plainly.

66120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 66120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 Wyndhurst Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Wyndhurst Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn New Gorman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife William G. Gorman, Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 25, 1880

8. AGE: Years	Months	Days	If less than one day: hr.	min.
67	7	28		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Charles W. New
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Nettie Dinger
15. Birthplace Baltimore

16 (a) Informant Mrs. Gladys G. Grim
(b) Address 612 Wyndhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery Loudon Park
Location 3801 Frederick Ave., Baltimore

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1800 Eutaw Place

AUG 24 1948 (Date rec'd by registrar)

Registrar

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1948, at 1.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to Aug 1948
and that I last saw her alive on Aug 21 1948

Immediate cause of death: Carcinoma of breast — Duration: 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature William G. Kelsick M. D.
Address 5006 Roland Ave. Date signed Aug 23, 48

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. 666121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 Scott St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Scott St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac H. Tucker

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Cora V. Tucker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11. 1872

8. AGE: Years 76 | Months 2 | Days 11 | If less than one day: hr. min.

9. Birthplace Annapolis Md
(Town, county, and state)

10. Usual Occupation Retired Laborer

11. Industry or business Gas & Electric Co

FATHER
12. Name John H. Tucker
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Jones
15. Birthplace Md.

16 (a) Informant Laura D. Harris
(b) Address 614 Scott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Mrs. John W. Culverson
(b) Address 5311 Edmondson Ave

19 Aug 24 1948 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1948, at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1947 to Aug 22 1948 and that I last saw h[illegible] alive on Aug 21 1948.

Immediate cause of death	Duration
Mitral Insufficiency	1½
Due to Generalized Arteriosclerosis	3yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 517 Scott St Date signed Aug 23/48

PLEASE WRITE PLAINLY, with ink. Do not use pencil. Be sure to give correct age in each case. This information is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

66122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66122

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2618 E. Preston.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 E. Preston. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John V. Bory.

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212- 12-6858

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie Bory

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Dec. 22. 1885

8. AGE: Years 62 | Months 8 | Days 0 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Bar Tender.

11. Industry or business Kof C. Club.

FATHER
12. Name George Bory.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Johanna Ritter.
15 Birthplace Baltimore Md.

16 (a) Informant Mrs. Minnie Bory
(b) Address 2618 E Preston. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 26th 48 (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer
Location Belair Rd

18 (a) Funeral director Geo. M. Fink & Son.
(b) Address #811 N. Wolfe. St.

19 AUG 24 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22nd. 1948 at 5pm M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 May 1948 to 22 Aug 1948. and that I last saw him alive on 22 Aug 1948.

Immediate cause of death: Heart Coronary Occlusion — Duration: 3 hrs

Due to Arteriosclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 1516 N. Milton Ave Date signed 24 Aug 48

PLEASE WRITE PLAINLY, with pen and ink. Fill in all blanks. Be sure and answer every question. Where none, or not known, write "None" or "Unknown". Please do not use abbreviations or ditto marks. Be sure to give the correct age in each case. Do not copy from a birth certificate. Do not guess the age. The ages of infants and the ages of persons who have been married or who have been engaged in any occupation are especially important. Physicians: please write the causes of death clearly and legibly.

V S 190

6123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 6663123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2253 Cecil Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2253 Cecil Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS RUSSELL ARNOLD

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	716-12-3476	male	white	married

6 (b) Name of husband or wife Jessie L. Arnold nee Grimes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 18, 1892

8. AGE: Years	Months	Days	If less than one day
55	9	3	hr. min.

9. Birthplace Westminster, Md. (Town, county, and state)
10. Usual Occupation Freight Conductor
11. Industry or business Penna. R. R.

FATHER
12. Name Alford Arnold
13. Birthplace Carroll Co.

MOTHER
14. Maiden Name Annie Ament
15. Birthplace Carroll Co.

16 (a) Informant Mrs. Jessie L. Arnold
(b) Address 2253 Cecil Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 AUG 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1948 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to 21 Aug 48 and that I last saw him alive on 21 Aug 48.

Immediate cause of death Uremia — Duration 11 d
Due to Calcification
Due to Cardio-vascular
Due to Disease. Abt 11 yrs.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. Carroll Gephart M. D.
2925 N. Charles Date signed 23 Aug 48

VS 30

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Please write correct age is especially important.

66124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G66124

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2126 Mt. Holly St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2126 Mt. Holly St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** JENNIE L. DENNIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Charles E. Dennis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1880

8. AGE: Years	Months	Days	If less than one day
68	7	20	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Rubin Hengst

13. Birthplace Penna.

MOTHER 14. Maiden Name Charlett Leber

15. Birthplace Penna.

16 (a) Informant Mr. Howard E. Demuth

(b) Address 4305 St. Paul St.

17 (a) Burial (b) Date thereof 8/24/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) AUG 24 1948 (b) Huntington Williams, M.D.
(Date recd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1948, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1948 to aug 21 1948 and that I last saw her alive on aug 21 1948

Immediate cause of death	Duration
Carcinoma - metastasis abdominal viscera	about 2 yrs.
Due to	
Due to primary, carcinoma of cervix -	2½ yrs.
Other Conditions Anemia	3 mo.

(Include pregnancy within 3 months of death)

Date of operation March 1946

Major findings of operation: Carcinoma of cervix

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Huntington Williams M. D.

Address 2220 Garrison Date signed aug 23/48

Please write plainly. Physicians: please write the causes of death clearly and legibly. Information as to correct age is especially important.

G66125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G66125

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1728 E. Balto St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1728 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Jukon Ozer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mollie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1855

8. AGE: Years 93 Months Days If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER

12. Name Samuel

13. Birthplace Poland

14. Maiden Name Rachael

15. Birthplace Poland

16 (a) Informant Marsha Rosenfeld

(b) Address 1728 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-24-48 (month) (day) (year)

(c) Cemetery or crematory

Location Herzog Herzog Funeral Home

18 (a) Funeral director Jack Lewis Inc

(b) Address 200 Eutaw Place

Filed AUG 24 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

19. DATE OF DEATH 8-24- 1948 at 3:05 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/18 1948 to 8/23 1948 and that I last saw him alive on 8/23 1948

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Cardiac Hypertrophy (Including pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice Shadoxd M. D.

Address 2725 Linden Ave Date signed 8/24/48

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6126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66126

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 642 - Sterling St.
(c) Hospital or institution: Johns Hopkins 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 642 Sterling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Phillip

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 87 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Eliza Taylor

13. Birthplace Va. ?

MOTHER 14. Maiden Name Lizzie ?

15. Birthplace Va.

16 (a) Informant Roosevelt Coleman

(b) Address 642 - Sterling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary.

Location

18 (a) Funeral director A. Halstead

(b) Address 91 E. Lanvale St.

AUG 24 19[illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22/48 19 at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH, Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ivers M.D.
Medical Examiner.
Date signed 8/22/48

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correct age is especially important. Physicians: please write the cause of death plainly.

G66127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

G66127 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 6 mos. 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 335 E. 30th St. # 18 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J. Clifford

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: MARY EDNA CLIFFORD
6 (c) If alive, give age: 59 years
7. Birth date of deceased (mo., day, yr)
8. AGE: Years 59 | Months 11 | Days 29 | If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Confectioner
11. Industry or business

FATHER
12. Name: THOMAS L CLIFFORD
13. Birthplace: ENGLAND

MOTHER
14. Maiden Name: CATHERINE WISEMAN
15. Birthplace: GERMANY

16 (a) Informant: MARY EDNA CLIFFORD
(b) Address: 335 E 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 26 48 (month) (day) (year)
(c) Cemetery or crematory: NEW CATHEDRAL
Location: Edmondson Ave

18 (a) Funeral director: Charles F. Evans & Son Inc
(b) Address: 118 W. Mt. Royal Ave Baltimore, Md.

AUG 4 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23 1948, at 7:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3 1948 to 8/23 1948, and that I last saw him alive on 8/22 1948.

	Duration
Immediate cause of death: Congestive myocardial failure	1 week
Due to: Hypertensive C-V Renal Disease	? years
Due to:	
Other Conditions: Chronic fibroid apical tuberculosis, bilateral (include pregnancy within 3 months of death)	? years

Date of operation:
Major findings of operation:
of autopsy: 8/23/48 - same as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Alfred H. Dann M. D.
Address: Maryland General Hosp. Date signed 8/23/48

Please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

131a

G66128

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

G66128
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gates & Fulton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2902 O'Donnell St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Greece

3 (a) FULL NAME James Spilotis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/7/1880

8. AGE	Years	Months	Days	If less than one day
	68	6	13	hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Restaurant (Retired)
11. Industry or business

FATHER
12. Name Georges
13. Birthplace Greece

MOTHER
14. Maiden Name Thomais
15. Birthplace Greece

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox
Location Evangelismos

18 (a) Funeral director Sts. St. Agnes Funeral Home
(b) Address 118 N. Mt. Royal Ave.

19 (a) Date 1948 registrar entering for Philemon Bell, M.D. registrar

AUG 26

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/48 19 . at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 19 48 to 8/20 19 48.
and that I last saw him alive on 8/20 19 48.

Immediate cause of death Cardiac failure
Due to Hypertensive c.v.
Due to Generalized toxemia
Due to Lobar pneumonia - right middle & lower
Other Conditions Cirrhosis -
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Dr. Howard

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. D. Venable, Jr. M.D.
Address St. Agnes Hospital Date signed 8/20/48

correct age is especially important. Physicians: please write out the words.

G66129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G66129 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 W. Lexington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
1629 W. Lexington St.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hollis Or Flory Hollins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female

5 Color or race Col.

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 1. 1885

8. AGE Years 63 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Waterberry. A. A. Co. Md
(City, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Galloway
13. Birthplace Waterberry A. A. Co. Md

MOTHER
14. Maiden Name Amelia Taska
15. Birthplace Calvert Co. Md

16 (a) Informant Jane Johnson
(b) Address 1629 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 24. 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery. Cem.
Location Brooklyn. Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address Granby Ave.

AUG 24 1948 (Date rec'd by registrar) (b) Huntington Ave Norfolk, Va. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/48 19 . at 84 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17/48 19 . to 8/20/48 19 .
and that I last saw h[illegible] alive on 8/17/48 19 .

Immediate cause of death Bronchial Pneumonia
Myocarditis acute

Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter T. Hoover M. D.
Address 40 Edmondson Date signed 8/24/48

correct age is especially important. Physicians: please write the cause of death plainly.

VS 15

G66130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓47D

G66130 Registered No.

IB 121403

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Balto. City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo. 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Orleans Str. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy House

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Rose Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar. 18, 1900

8. AGE: Years 48 | Months 5 | Days 4 | If less than one day: hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Perry House
13. Birthplace N.C.

MOTHER
14. Maiden Name Savana Langley
15. Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave/

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 000 Baltimore ave

AUG 24 1948
(Date rec'd by registrar)

Huntington Williams, M.E.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22 1948, at 5:40PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19- 1948, to 8-22- 1948 and that I last saw h in alive on 8-22- 1948.

Immediate cause of death Resp. failure — Duration 1 day

Due to Ca of lung, mets — Duration mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation ✓

Major findings of operation: ✓

of autopsy: Ca of lung, mets

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Balt City Hosps Date signed 8-23-48

VS 50

Correct age is especially important. Physicians: please write the entries in this space.

G66131

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66131

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 40 S. Bond St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 40 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Gertrude Cullison

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex Female | 5 Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James Cullison
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) April 15 1898

8. AGE: Years 50 49 | Months 4 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace St. Marys Co. Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name George Cullison
13. Birthplace St. Marys Co. Md.

MOTHER
14. Maiden Name Henrietta Shorter
15 Birthplace St. Marys Co. Md.

16 (a) Informant James Lawson
(b) Address 40 S. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 25. 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Brooklyn Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1009 Brantly Ave.

19 (a) AUG 24 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1948, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1948 to Aug. 23 1948, and that I last saw h[illegible] alive on Aug 21 1948.

Immediate cause of death Myocarditis Diabetes, Mellitus, Nephritis — Duration ?

Due to [illegible]

Due to

Other Conditions Abor

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Angler M. D.
Address 1634 E. Baltimore Date signed 8-24-48

To be signed by Medical Examiner
Thomas H. Martin M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66132 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 S. Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE LYONS (GERTRUDE M. WELCH)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Louis Lyons

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-11-1918

8. AGE: Years 30 | Months 7 | Days 11 | If less than one day hr. min.

9. Birthplace Balto Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER
12. Name Jerome J Saddler
13. Birthplace Balto Co Md
14. Maiden Name Laura V McFaltridge
15. Birthplace Balto Co Md

16 (a) Informant
(b) Address 3505 Wash Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-48 (month) (day) (year)
(c) Cemetery or crematory, Mt Olivet
Location Frederick Rd

18 (a) Funeral director Edward Poulson
(b) Address 1937 Wash Blvd

(Signature of Registrar) (b) Registrar

VS 15:

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1948, at 12:30 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Upper Respiratory Infection

Other Conditions Fatty Degeneration of liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royston M.D. (Medical Examiner)

Date signed August 23, 1948

correct age is especially important. Physicians: please write the cause of death clearly

G66133

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G66133

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly, correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 Hamilton Ave. #14 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Malcolm Edwards

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-01-5466

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ wife: Augusta Masson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1877

8. AGE: Years 70 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Accountant
11. Industry or business Maryland Tobacco Co.

FATHER
12. Name Thomas Edwards
13. Birthplace England

MOTHER
14. Maiden Name Margaret McCleary
15. Birthplace Ireland

16 (a) Informant Malcolm M. Edwards
(b) Address Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Parkville, Balto. Co., Md.

18 (a) Funeral director John Burns Sons
(b) Address Towson, Md.

19 (a) AUG 24 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1948, at 11:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1948, to 8/22 1948, and that I last saw him alive on 8/22 1948.

Immediate cause of death: Pulmonary edema / Cardio-respiratory failure — Duration: 1 hour

Due to: Arteriosclerotic Heart Disease — ? years

Due to: Pneumonia, right base — 12 days

Other Conditions: Uremia — 12 days; Diabetes mellitus — ~~? years~~

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred H. Dann, M. D.
Address Maryland General Hosp. Date signed 8/22/48

93D

G66134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66134

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14-1
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME JOSEPH PECORA

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 128-07-2192

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife ?

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 12, 1889

8. AGE: Years 59 | Months 2 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace New York, N. Y.
(Town, county, and state)

10. Usual Occupation Supt.

11. Industry or business Wm. T. Lyons Co., Inc.

FATHER
12. Name Domenick G. Pecora
13. Birthplace Italy

MOTHER
14. Maiden Name Agnes Marchese
15. Birthplace Italy

16 (a) Informant Mr. Anthony W. Pecora
(b) Address 46 Hudson Ave., Waldwick, N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/48 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 24 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1948, at 12:45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?
(d) Means of injury .....

23. Signature Homer J. Wilkens M.D.
Medical Examiner.
Date signed 8-23-48

VS 151

X

Copyright age is especially important. Typewriter, please write the date of [illegible]

G666135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G666135
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 851 Park Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN THOMAS WENTWORTH

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Eva B. Wentworth
nee Hubert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1885

8. AGE:

Years	Months	Days	If less than one day
63	7	22	hr. min.

9. Birthplace: Balto., Md.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Oliver E. Wentworth
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Catherine Hubbard
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Ferdinand A. Foertsch
(b) Address: 2638 Mathew St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) 4 1948 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1948, at 4.15 a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George H. Merrill M.D.
Medical Examiner.
Date signed August 23, 1948

correct age is especially important. Physicians: please write the

G66136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G66136 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 Darley Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 Darley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA S. RIGNEY

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: John Rigney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Aug. 31, 1861

8. AGE: Years: 86 | Months: 11 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: - Albin
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Mr. Christian Wickland, son-in-law
(b) Address: 1607 Darley Ave.

17 (a) Burial (Burial, cremation, or removal) **(b)** Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: M. J. TICKNER & SONS
(b) Address: Balto., Md.

(c) Date rec'd by registrar 8/24/48 **(b)** Registrar Lexington for Williams, MD

V.S. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1948, at 8:00 M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/21 1948 to 8/22 1948 and that I last saw her alive on 8/21 1948

Immediate cause of death: Bronchopneumonia — Duration

Due to: Arteriosclerotic - C.V.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Christian F. Riddle M. D.
Address 11 W. Biddle Date signed 8/24/48

correct age is especially important. Physicians: please write the cause of death plainly.

6137 G66137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 548

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 141 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 5910 Falls Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: HARRY RAY WOODS

3 (b) If veteran, name war: VA I

3 (c) Social Security Account No.: 214-12-8565

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): Feb. 26, 1893

8. AGE: Years: 55 | Months: 5 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Balto, Md. (Town, county, and state)

10. Usual Occupation: Painter

11. Industry or business:

FATHER 12. Name: Geo. Woods
13. Birthplace: Balto, Md.

MOTHER 14. Maiden Name: Emmie Taylor
15 Birthplace: Balto, Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: Frederick Rd Balto Md

18 (a) Funeral director: Geo J Ruth Inc
(b) Address: 1735 Hartford Ave

19 (a) AUG 24 1948 (Date received by Registrar) (b) Huntington, Md.

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 23 1948 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 4 1948 to Aug. 23 1948, and that I last saw him alive on Aug. 23 1948.

Immediate cause of death: Postoperative state: craniotomy right temporal — Duration:

Due to:

Due to:

Other Conditions: Pulmonary atelectasis right upper & middle lobes (Include pregnancy within 3 months of death) — Duration: Several months

Date of operation: 4/19/48

Major findings of operation: Mass in right hemisphere

of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon
Address: Clinical Director Date signed: 8/24/48 M. D.

X

G66138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G66138

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or [illegible]
St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 N. Regester St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Seufert, Barbara Magdalene (Barbara M. Seufert)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Philip P. Seufert

6 (c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): Dec. 12, 1874

8. AGE: Years: 73 | Months: 8 | Days: 11 | If less than one day: ########## min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Philip Hoffman
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna M. Huth
15. Birthplace: Germany

16 (a) Informant: Philip P. Seufert
(b) Address: 1817 N. Regester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-48 (month) (day) (year)
(c) Cemetery or crematory: Most Holy Redeemer
Location: 4430 Belair Rd. Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

AUG 24 1948 (Date rec'd by Registrar) [signature] Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23, 1948, 11:10AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 19, 1948 to Aug. 23, 1948, and that I last saw her alive on Aug. 23, 1948.

	Duration
Immediate cause, of death: Cerebral-Vascular accident	
Due to: Hypertensive Cardio-Vascular disease	
Due to: Generalized Arteriosclerosis	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury:

23. Signature: Roy E. Person Jr. M. D.
Address: St. Joseph Hosp. Date signed: Aug 23 1948

X

correct age is especially important. Physicians: please write plainly and use ink or indelible pencil

139 BC – 48-17666 BALTIMORE CITY HEALTH DEPARTMENT 159 Registered No. C66139
AB-122293

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: 26
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) Stars-
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
6 (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Parry Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Berry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 21-1948

8. AGE: Years	Months	Days	If less than one day
			5 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charlie Berry
13. Birthplace S.C.

MOTHER
14. Maiden Name Archiebell Evans
15. Birthplace S.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (b) Date thereof Aug 23 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bolt Crematory Hwy
Location 4940 Eastern Ave

18 (a) Funeral director
(b) Address

19 AUG 24 1948 (b) Baltimore, Md.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21- 1948, at 1.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21- 1948 to 8-21- 1948, and that I last saw h er alive on 8-21- 1948.

Immediate cause of death Prematurity — Duration 8 hrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Holmes M. D.
Address BCH Date signed Aug 23

correct age is especially important. Typewriter preferred.

G66140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. G66140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3416 Virginia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimpre
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3416 Virginia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Josephine Whyte.

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Albert M. Whyte.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1876

8. AGE: Years 72 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Easton, Pa.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business at home

FATHER
12. Name Schultz,
13. Birthplace unknown,

MOTHER
14. Maiden Name unknown,
15. Birthplace unknown,

16 (a) Informant Mr. Albert M. Whyte.
(b) Address 3416 Virginia Ave.,

17 (a) burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.,

AUG 24 1948
(Date rec'd by registrar) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1948 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 19[illegible] to 8/23 1948, and that I last saw her alive on 8/22 1948.

Immediate cause of death CARCINOMA of PANCREAS — Duration 9 Months

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Manuel Lein M. D.

Address 4818 Reisterstown Rd. Date signed

V S 190

PLEASE WRITE PLAINLY. Fill in all blanks completely. Physicians: please write the causes of death clearly and legibly. Cause of death is especially important.

G66141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G66141

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2411 Annapolis Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Westport (If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 Annapolis Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Melvin John Kilbourne

3 (b) If veteran, name war: WW #2
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 8, 1907

8. AGE: Years 40 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Key Highway Shipyard

FATHER
12. Name Frank Kilbourne
13. Birthplace Md

MOTHER
14. Maiden Name Nancy E. Cooden
15. Birthplace Md

16 (a) Informant Nancy E. Kilbourne
(b) Address 2411 Annapolis Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave

18 (a) Funeral director John F. Penny Inc
(b) Address 715 Light St.

19 AUG 25 1948 (Date rec'd by Local Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1946, to Aug. 23 1948, and that I last saw him alive on Aug. 7, 1948.

Immediate cause of death: Coronary Thrombosis — Duration
Due to: Hypertensive Cardio-Vascular Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Brooke
Address 1331 Eastern Ave Date signed 8-24-48

6142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G66142 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible]
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Days.
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Pontiac Ave #25 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Elliott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Grace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6/16/83

8. AGE: Years 65 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Mover

11. Industry or business

FATHER
12. Name George W. Elliott
13. Birthplace Virginia

MOTHER
14. Maiden Name Betty Sylvia
15. Birthplace Virginia

16 (a) Informant Mrs Grace Elliott
(b) Address 410 Pontiac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St. -30

19 AUG 25 1948 (Date received by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1948, at 2254 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 19 48 to 8/26 19 48 and that I last saw h i m alive on 8/23 19 48.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertension Heart Disease	
Due to	
Other Conditions Carcinomatosis C Metastases ?	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Maryland Ave Date signed 8/24/48 M D

PLEASE WRITE PLAINLY. Fill in all blanks correctly. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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937

G66143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G66143

PLEASE WRITE PLAINLY, with unfading ink. Use no abbreviations. Do not leave any blanks. If unknown, or not applicable, write none. Be sure that the information you give is full and correct as to each item. Accuracy and completeness are essential. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1219 LIGHT ST.
(c) Hospital or institution: SOUTH BALTO. GEN HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 MONTHS 8 DAYS.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County ANNE ARUNDEL
(c) City or town BROOKLYN, MD. (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 DORIS AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SCHNEPFE, NANNIE A.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daniel Schnepfe

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) August 11, 187[illegible]

8. AGE: Years 71 | Months | Days 11 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: None

11. Industry or business: None

FATHER
12. Name: Curtis M. Lee
13. Birthplace: Md

MOTHER
14. Maiden Name: Almeda Jacobs
15. Birthplace: Md

16 (a) Informant: Mr Daniel Schnepfe
(b) Address: 500 Doris Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Annapolis Blvd

18 (a) Funeral director: John F Kenney Inc
(b) Address: 715 Light St

AUG 25 1948 (Date rec'd by Registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 22 1948 at 7⁰⁵ PM

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 15 1948 to AUG 22 1948. and that I last saw HER alive on AUG 22 1948.

Immediate cause of death: HYPOSTATIC PNEUMONIA — Duration
CARDIO RESP. FAILURE
Due to ARTERIOSCLEROSIS GENERALIZED
Due to DIABETES MELLITUS
MIDTHIGH AMPUTATION (RT.)
Other Conditions (POST OP.)

(Include pregnancy within 3 months of death)
Date of operation MIDTHIGH AMP. 8/6/48
Major findings of operation: ARTERIOSCLEROSIS
of autopsy: ARTERIOSCLEROSIS, PNEUMONIA

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: William B. Cooper Jr M. D.
Address: SOUTH BALTO. GEN HOSP. Date signed 8/22/48

G66144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66144

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 MARSHALL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 MARSHALL ST. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME ANNA HUSTER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife GEORGE HUSTER
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr) JAN. 9, 1868

8. AGE: Years	Months	Days	If less than one day
80	7	13	hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name AUGUST OTTO
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANNA WEISS
15 Birthplace GERMANY

16 (a) Informant P. AUGUST GRILL
(b) Address 1204 FIDELITY BLDG

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory LAUDUN PK.
Location FREDERICK RD.

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST. -30

19 (a) AUG 25 1948 (b) Huntington Williams M.E.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1948, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1948 to 8-21 1948 and that I last saw h[illegible] alive on 8-21 1948

Immediate cause of death [illegible] Duration

Due to myocardial degeneration

Due to arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Denis J. McGrath M.D.
Address 1E. Randall St. Date signed 8/23/48

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66145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G66145

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3814 Gelston Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 Gelston Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Balsis

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-4493

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	married

6 (b) Name of husband or wife Ursula

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Ursula Balsis
(b) Address 3814 Gelston Drive

17 (a) Burial (b) Date thereof 8 25 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Blair Road

18 (a) Funeral director Joseph Kaasmeyer Inc
(b) Address 602 Wash Blvd

19 AUG 25 1948 (b) Huntington & Williams
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24 1948, at 10:05 A.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular disease

Due to Arteriosclerosis Generalized

Other Conditions Senility
Contusion left eye.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert E. McFadden M.D.
Medical Examiner.
Date signed 8-24-48

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correct age is especially important, as upon it depends the amount of insurance payable.

5146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G66146
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 736 George St.
(c) Hospital or institution: Baltimore Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edna Thomas B. Jagman.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F. 5. Color or race C. 6 (a) Single, married, widowed, or divorced. W.
6 (b) Name of husband or wife Robert Garnett.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1903
8. AGE: Years 45. Months Days If less than one day hr min.
9. Birthplace St. Michels Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Frank Thomas.
13. Birthplace St. Michels

MOTHER
14. Maiden Name Unknown.
15. Birthplace St. Michels

16 (a) Informant Mrs Ellen Pearson
(b) Address 736 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Port. Balto. Md.

18 (a) Funeral director Metropolitan Fun. Home Inc.
(b) Address 907 N. Mount St.

AUG 25 1948 (Date rec'd by registrar) (By) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23 1948 at 8.55 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1948 to 8/23 1948, and that I last saw her alive on 8/23 1948.
Immediate cause of death Cerebral Hemorrhage
Duration 7 Days
Due to
Due to Nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William Garner
Address 736 George St Date signed 8/27/48 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. G66147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-10
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3904 ± Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MORRIS KLING

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Lena
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1895

8. AGE	Years	Months	Days	If less than one day
	63			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER	12. Name Philip
	13. Birthplace Russia
MOTHER	14. Maiden Name Koplitz
	15. Birthplace Russia

16 (a) Informant Lena Kling
(b) Address 3904 ± Boarman Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-48 (month) (day) (year)
(c) Cemetery or crematory Sinai Israel
Location Northern Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 2166 Eutaw Place
AUG 25 1948 (Date Received by Registrar) (By) Registrar

PLEASE WRITE plainly with pen or pencil and make no erasures. Physicians: please write the cause of death clearly and correct age is especially important.

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MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1948, at 9:05 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16 1948, to Aug. 24 1948, and that I last saw him alive on Aug 24 1948.

	Duration
Immediate cause of death Bronchopneumonia	
Due to	
Due to	
Other Conditions Hypernephroma c metastasis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Bronchopneumonia, Hypernephroma, Cardiac

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Adams M. D.
Address Sinai Hosp. Date signed 8-24-48

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G66148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G66148

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address City Jail Infirmary
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 W Fitzhugh Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Gunning (colm)

3 (b) If veteran, name war Mil 1st

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Esther C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5 1891

8. AGE: Years 57 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Texas Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Michael J Gunning

FATHER 13. Birthplace Md

MOTHER 14. Maiden Name Catherine Atkinson

MOTHER 15. Birthplace Ireland

16 (a) Informant Mrs Esther Gunning

(b) Address 716 Kendall Ave

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 8/26/48 (month) (day) (year)

(c) Cemetery or crematory National

Location Baltimore Md

18 (a) Funeral director Pulliam Bros Inc

(b) Address 1217 E Fayette

19 (a) AUG 25 1948 (Date rec'd by registrar) (b) Cumberland for Williams, Mills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1948, at 3 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While (what) work?
(d) Means of injury

23. Signature E. R. Long M.D. (Medical Examiner)
Date signed 8-24-48

correct age is especially important for insurance purposes

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G66149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948 B866148

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 921 GRANBRY ST
(c) Hospital or institution:
Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Granby St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MATTHEW MOORE

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 10. 1871

8. AGE: Years: 76 | Months: 10 | Days: 13 | If less than one day: hr. min

9. Birthplace CALIFORNIA (Town, county, and state)

10. Usual Occupation SHIP WATCHMAN

11. Industry or business

FATHER
12. Name MICHAL JOS MOORE
13. Birthplace DUBLIN IRELAND

MOTHER
14. Maiden Name ELLEN TOY
15. Birthplace IRELAND

16 (a) Informant: GEORGE T MOORE
(b) Address 3656 N. LAKEWOOD CHICAGO-ILL

17 (a) (Burial, cremation, or removal) (b) Date thereof Aug 24-4 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR RD

18 (a) Funeral director ELLSWORTH HAMMOND
(b) Address 3911 LIBERTY HEIGHTS AVE

19 (a) AUG 25 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, at 6.20p M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arterio-sclerotic - C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Royer M.D.
Medical Examiner.
Date signed August 18, 1948

correct age is especially important. Physicians: please write all causes of death clearly.

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66150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34
(e) Length of stay in Baltimore (yrs., mos., or days) 34 days

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County Long Island
(c) City or town East Hampton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Chester Martis Cloud.

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	widowed

6 (b) Name of husband or wife: May Christine Cloud
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Apr 4 1884.

8. AGE: Years	Months	Days	If less than one day
64	4	20	hr. min.

9. Birthplace: Woodbury N.J. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: Mr Josiah G Cloud
13. Birthplace: Mt. Ephram N. J.

MOTHER
14. Maiden Name: Lucille W Marts
15. Birthplace: Mauricetown N.J.

16 (a) Informant: Mr. G. Walther Ewalt
(b) Address: Beverly Hall, Millersville, Md.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8/25/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Crematory
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) AUG 25 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1948, at 9 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1948 to Aug 24 1948, and that I last saw him alive on Aug 20 1948.

Immediate cause of death: Pulmonary Congestion — Duration 48 hrs.

Due to: Hypertensive Arterio-sclerotic Heart Disease — Duration 5 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John R. Smith Jr. M.D.
Address: Union Memorial Hospital
Date signed 8/27/48

correct age is especially important. Physicians, please cooperate.

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66151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 66151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2507 Francis St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2507 Francis St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thaddeus S. Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	divorced

6 (b) Name of husband or wife Thelma Irene Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1899

8. AGE: Years	Months	Days	If less than one day
49	1	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Balto. Transit Co.
11. Industry or business Retired

FATHER
12. Name Ellsworth D. Johnson
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Alverta Bennett
15. Birthplace Balto., Md.

16 (a) Informant Mrs. E. T. Bowling, daughter
(b) Address 5009 Beaufort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 25 1948 (Date rec'd by registrar) (b) Tuntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 24 1948 at 11 20 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio Vascular Disease

Due to Arteriosclerosis Generalized

Other Conditions Cerebro-Vascular Accident (old).
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D.
Medical Examiner.
Date signed 8-24-48

VS 151

correct age is directly important for comparative purposes

66152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 66152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 335 S Smallwood St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 335 S Smallwood St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Margaret Cecelia Singer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced:
6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-4-1888

8. AGE: Years 60 | Months 6 | Days 20 | If less than one day: hr. min.

9. Birthplace Baltimore City
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Singer
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie Gies
15. Birthplace Germany

16 (a) Informant Sadie E Sanders
(b) Address 335 S Smallwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Rd

18 (a) Funeral director Robt C. V. B'dw. Walters
(b) Address Pratt & Shuckers Sts

19 (a) AUG 25 1948 (Date rec'd by registrar) Huntington Williams
(b) —

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1947 to 8/24 1948 and that I last saw her alive on 8/23 1948.

Immediate cause of death: Myelogenous Leukemia — Duration 18 mos

Due to Myelogenous

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury —

23. Signature Albert D Kahn Jr M. D.
Address 2030 Wilkens Ave
Date signed 8/27/48

correct age is especially important. Physicians, please give the exact

X

66153

AB-122082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G66153

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.,
(c) Hospital or institution:
Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willnett Birdsong

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Marner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept-8-1896

8. AGE: Years	Months	Days	If less than one day
51	11	13	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Thomas Blake (D
13. Birthplace Md.

MOTHER
14. Maiden Name Eleanor Brown
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Aug. 26, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Geo. W. Hyldon
(b) Address 631 Druid Hill Ave.

AUG 25 1948
(Date rec'd by registrar)

(by) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21- 1948, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13- 1948, to 8-21- 1948, and that I last saw her alive on 8-21- 1948.

Immediate cause of death	Duration
Uremia	2 wks.
Due to Hypertensive cardio-vascular-renal disease	5 yr.
Due to	
Other Conditions Pulmonary Edema	3 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Hypertensive Cardio-vascular-renal disease

of autopsy: Hypertensive Cardiovascular Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Steinman M. D.
Address Balto. City Hosp. Date signed 8-22-48

correct age is especially important

VS 15

X

6154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered No. G66154

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4831 Keswick Rd.
(c) Hospital or institution:
27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4831 Keswick Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette F. Griffin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 18 1929

8. AGE: Years	Months	Days	If less than one day
18	10	5	..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John A. Griffin
13. Birthplace Md.

MOTHER
14. Maiden Name Beulah F. Mitchell.
15. Birthplace Md.

16 (a) Informant John A. Griffin
(b) Address 4831 Keswick Rd.

17 (a) Burial, cremation, or removal Burial **(b) Date thereof** Aug. 26 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave.

18 (a) Funeral director Paul E. Kennedy Jr.
(b) Address 2417 Chestnut Ave.

19 AUG 25 1948 (Date received by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1948, at 7.20 M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1948 to Aug 23 1948 and that I last saw her alive on Aug 23 1948.

Immediate cause of death Hodgkin's Disease — **Duration** 5 years

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William F. Pearce M. D.
Address 205 N Charles St Date signed Aug 25 1948

correct age is especially important. Physicians: please write the cause

VR 150

X

6155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G66155

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp - 6 - DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 E. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUGENE CORNISH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace " "

MOTHER
14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant Annie Jones
(b) Address 1502 E Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25-48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Brooklyn Md

18 (a) Funeral director Thos O. Wilson
(b) Address 1100 Bloomfield ave

AUG 25 1948 (Date rec'd by registrar) (b) Burlington N.J.

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MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24/1948, at 6 10 A M

21. I certify that I took charge of the remains described above, held an Inspection and Inq thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edgar F. Merrill M.D.
Medical Examiner.
Date signed 8/27/48

correct age is especially important. Physicians: please write the cause of death plainly.

6156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G66156

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Jasper St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Jasper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William F. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-9615

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1872

8. AGE: Years	Months	Days	If less than one day
76	10	19	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business Waters Caterer

FATHER
12. Name Isaac Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Clara Smith
15. Birthplace Maryland

16 (a) Informant James A. Jones
(b) Address 406 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/37 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location Arbutus Md.

18 (a) Funeral director Charles S. Law
(b) Address 802 Madison Ave.

19 (a) AUG 25 1937 (Date received by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1937, at 2 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebro-Sclerosis - C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed Aug 25 37

VS 151

correct age is especially important. Physicians: please write the causes of death

6157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G66157

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 E.28th., Street
(c) Hospital or institution: 12-
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 E.25th., Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Joseph DeBaufre

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-14-4544

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Iris Ann Hoffman
6 (c) If alive, give age 18 years

7. Birth date of deceased (mo., day, yr.) May 30, 1922

8. AGE: Years	Months	Days	If less than one day
26	2	23	###### min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Truck Helper
11. Industry or business Mc Carthy-Hicks Co.,

FATHER
12. Name Benjamin DeBaufre
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Lynch
15 Birthplace Baltimore, Md.

16 (a) Informant George DeBaufre--Brother
(b) Address 1452 Montpelier Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery or crematory Morlands Park
Location Taylor Avenue, Balto. Co. Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 AUG 25 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23rd., 1948 at 6-PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/21 1948 to 8/23 1948.
and that I last saw h[illegible] alive on 8/2 1948.

	Duration
Immediate cause of death: Coronary Thrombosis	Sudden
Due to: Rheumatic Heart Disease	2 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 114 W. Calvert Date signed 8/24/48

V S 150

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G66158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G66158
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.
(c) Hospital or institution:
Mrs Snyders Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 N. Washington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAVINIA KING

3 (b) If veteran, name war NO

3 (c) Social Security Account No. NONE

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1863

8. AGE: Years 84 | Months 9 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Montgomery County, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? King
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs John Myers
(b) Address 3722 Rexmere Rd.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 8/ 25/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) AUG 25, 1948 (Date received by registrar) **(b)** Huntington Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1948, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1948 to Aug 22 1948
and that I last saw her alive on Aug 22 48

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertension	
Due to:	
Other Conditions: Senility, Partial Hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter A Leidum M. D.
Address 305 Hamilton Blvd **Date signed** 8/23/48

VS 150

Please write clearly and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161

Registered No. G66159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2715 Inglewood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2715 Inglewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NETTIE PENDELTON BAUER

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife John J. Bauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1872

8. AGE: Years	Months	Days	If less than one day
75	10	11	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Stiff
13. Birthplace Virginia

MOTHER
14. Maiden Name Nettie Wood
15. Birthplace Virginia

16 (a) Informant Mrs Frederick Ball
(b) Address 2715 Inglewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland
HENRY SANDER & SONS, INC.

18 (a) Funeral director
(b) Address NORTH AVE. & BROADWAY

AUG 25 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH August 23, 1948 at 3.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1948 to Aug 23 1948, and that I last saw her alive on Aug. 20 1948.

	Duration
Immediate cause of death: acute cardiac dilatation	20 mi.
Due to: carditis.	3 yrs.
Due to:	
Other Conditions: arterio-sclerosis, hypertension, diabetes. (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. E. Whitehead
Address 447 N. Kenwood Ave Date signed Aug 24 48

VS 190

95c

PLEASE WRITE PLAINLY with ink. Physicians: please write the causes of death clearly, and report correct age is especially important.

G66160

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G66160
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4614 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bass, Sylvia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife late Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1876

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Louis Yarisoffski
13. Birthplace Russia

MOTHER
14. Maiden Name Rose
15. Birthplace Russia

16 (a) Informant Abraham Potlock
(b) Address 4410 Towanda Ave.

17 (a) Burial (b) Date thereof Aug. 8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowley Lane

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1126 W. North Ave

19 (a) (b) Registrar
(Date rec'd by registrar)
AUG 25 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1948 at 8 1/2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1948 to Aug 25 1948, and that I last saw h er alive on Aug 25 1948.

Immediate cause of death Intracerebral hemorrhage, rt
Duration 20 hrs
Due to Arteriosclerotic & Hypertensive cardiovascular disease
many years
Due to (Cardiac enlargement) (Calcific aortic sclerosis)
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature Maurice D. Davis M. D.
Address West Balto. Gen. Hosp Date signed 8-25-48

correct age is especially important. Physicians, please write

G66161

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G66161 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 S. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK Philip P FABY, Jr. smt

3 (b) If veteran, name war WW II | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife STELLA FLORENCE FABY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST-15-1919

8. AGE: Years 29 | Months - | Days 9 | If less than one day hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation POLICE

11. Industry or business NORTH EAST DISTRICT

FATHER 12. Name FRANK FABY

13. Birthplace UNKNOWN

MOTHER 14. Maiden Name MARY BUNK

15. Birthplace UNKNOWN

16 (a) Informant STELLA FLORENCE FABY

(b) Address 822 SOUTH KENWOOD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-28-48 (month) (date) (year)

(c) Cemetery or crematory ST. STANISLAUS

Location BALTIMORE MD

18 (a) Funeral director George A. Weber

(b) Address 705 South Ann st

19 (a) 1948 (b) Registered by registrar Registrar

VS 151

MEDICAL CERTIFICATION 45

20. DATE OF DEATH August 24, 1948, at 10 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8-24-48

Correct age is especially important. Physicians: please write the cause or death clearly and legibly.

666162

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170c

Registered No. 666162

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 Liberty Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN Alfred BLUM

3 (b) If veteran, name war: World War #2

3 (c) Social Security Account No. 219-20-1398

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1925

8. AGE: Years	Months	Days	If less than one day
22	7	29	hr. min.

9. Birthplace Westminster, Md. (Town, county, and state)

10. Usual Occupation UNKNOWN

11. Industry or business

FATHER
12. Name William A. Blum
13. Birthplace Maryland

MOTHER
14. Maiden Name Jane Denform
15. Birthplace Maryland

16 (a) Informant: Hospital Records
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery or crematory Sandymount
Location Finksburg, Maryland

18 (a) Funeral director: J. Francis Reese
(b) Address Westminster, Md.

19 (a) AUG 25 1948 (Date received by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948, at 1:10 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushed chest
Ruptured inferior vena cava

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-24-48 at 3:00 A.M.
(b) Where did injury occur? Reisterstown Rd. 200' s. of Roaches Lane
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
Means of injury Auto into parked auto

23. Signature Emil Beyer M.D.
Medical Examiner.
Date signed 8-25-48

correct age is especially important. Physicians: please write the cause of death

C66163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. C66163

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 22 N. Carey St.
(c) Hospital or institution:
Good Samartian Home 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Wesley Carlyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary B. Carlyle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 27, 1868

8. AGE: Years	Months	Days	If less than one day hr.	min.
79	11	26		

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Lather
11. Industry or business

FATHER
12. Name Henry W. Carlyle
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary E. Meseroll
15. Birthplace New Jersey

16 (a) Informant Miss Irene D. Carlyle
(b) Address 627 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 26, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Wilbur Lemmon
(b) Address 1003 W. Baltimore St.

AUG 25 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1948 at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18/48 19.. to 8/23/48 19.., and that I last saw him alive on 8/18/48 19..

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. F. Loos M. D.
Address 4012 Edmondson Ave Date signed 8/24/48

PLEASE WRITE PLAINLY, with ink. Fill in all blanks. Be sure and answer every question. Be sure the information as to name, residence, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66164 BALTIMORE CITY HEALTH DEPARTMENT G66164

CERTIFICATE OF DEATH

183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Foot of Ann Street 2-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD HANSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE:	Years	Months	Days	If less than one day
	63			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25-48 (month) (day) (year)

(c) Cemetery or crematory Green Mount Cemetery

Location York Road.

18 (a) Funeral director Elizabeth Prescott

(b) Address 3911 Liberty Heights Ave

19 Aug 25 1948 (Date rec'd by reg.) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21, 1948, at 6:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Found: 8-21-48 at 6:15 A.M.

(b) Where did injury occur? Found: Harbor: Ft. of Ann St.

(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? no

(d) Means of injury Found Drowned

23. Signature Edward Rowan M.D. Medical Examiner

Date signed 8-23-48

Correct age is especially important. Physicians: please write the cause of death clearly.

G66165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66165 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St.
(c) Hospital or institution: Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 Augusta St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine L. McDermott

3 (b) If veteran, name war: No
3 (c) Social Security Account No. no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1913

8. AGE: Years 35 | Months 0 | Days 14 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Domestic Work

11. Industry or business With Private Families

FATHER
12. Name Patrick J. McDermott
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah A. Knight
15. Birthplace Ireland

16 (a) Informant Mrs. Nora Rowland
(b) Address 1624 Holbrook St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-48 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Charles W. Conklin
(b) Address 924 E. Eager St.

AUG 25 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24/48 19 to 8/24/48 19, and that I last saw h alive on 8/24/48 19

Immediate cause of death
Acute Myocarditis — Duration: few hours

Due to Multiple Seizures — Duration: 11

Due to Uremia Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. F. Doran M.D.
Address 20 E. Eager St. Date signed 8-25-48

Please write plainly. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

V S 190

G66166 BALTIMORE CITY HEALTH DEPARTMENT G66166

CERTIFICATE OF DEATH 170c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Peach Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Addie Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Charles Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER 12. Name Pearl Evans

13. Birthplace Ga.

MOTHER 14. Maiden Name Mollie Borrington

15. Birthplace Ga.

16 (a) Informant Charles Williams

(b) Address 1023 Peach Alley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director James A. Davis

(b) Address 1142 Hollins St.

19 (a) AUG 25 1948 (Date received by registrar) Huntington Williams, M.D.

(b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21, 1948, at 2:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism

Mesenteric Thrombosis

Due to Thrombophlebitis.

Other Conditions Internal Derangement of Rt Knee

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 23/

(a) Date of injury July 24, 1948, 11:45 p.m. M.

(b) Where did injury occur? Hanover & Henrietta Sts.

(c) Did injury occur at home, on farm, industrial place, in public place? Intersection While at work? No

(d) Means of injury Struck by truck

23. Signature Carl L. Voegler M.D.
Medical Examiner.

Date signed 8/23/48

correct age is especially important. Physicians: please write the cause of death plainly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Road + Herring Run
(c) Hospital or institution: Sydenham
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 18

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 N. Bond St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua Matthews
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Alberta
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. ?, 1910
8. AGE: Years 37 | Months 9 | Days | If less than one day hr. min.
9. Birthplace Winston-Salem, N.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thomas Matthews
13. Birthplace ?

MOTHER
14. Maiden Name ?
15 Birthplace ?

16 (a) Informant wife
(b) Address 602 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Baltimore Co.

18 (a) Funeral director Clay S. Wilson
(b) Address 1000 Baltimore Ave

AUG 25 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1948, at 2:32 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1948, to Aug 23, 1948, and that I last saw him alive on Aug 23 1948.

Immediate cause of death	Duration
Lt. Hemiplegia, Coma, Acidosis	
Due to Questionable Cerebral or -Vascular Accident	
Due to Questionable Intracranial Neoplasm	
Other Conditions Previous partial gastrectomy	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. S. Porter M. D.
Address Sydenham Hosp. Date signed 8-25-48

V S 150

A legible and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G66168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G66168

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Akron
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.D. Box 756
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) FULL NAME Arthur Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-3-29

8. AGE: Years 19 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Valentine Miller

13. Birthplace Pa

MOTHER 14. Maiden Name Agnes

15. Birthplace Pa

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Aug 25th
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Akron Ohio

18 (a) Funeral director Ulrich Funeral Home

(b) Address 200 E Exchange St

19 (a) Aug 25 1948 (b) Registrar
(Date received by registrar)

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1948, at 10:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1948 to Aug 25 1948 and that I last saw h[illegible] alive on Aug 25 1948.

Immediate cause of death Hemorrhagic Shock — Duration

Due to Operation - Exploration, Gastrectomy

Due to Congenital Heart Disease Tetralogy of Fallot

Other Conditions Incomplete

(Include pregnancy within 3 months of death)

Date of operation Aug 25, 1948

Major findings of operation See above

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. A. Cooley M. D.
Address JOHNS HOPKINS HOSPITAL Date Aug 25 48

Exact age is especially important. Physicians, please

AUG 25 1948

66169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. 66169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 N. Gilmore Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Lee Hatchett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Elizabeth Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/10/90

8. AGE: Years	Months	Days	If less than one day
58	1	14	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Hatchett
13. Birthplace Va.

MOTHER
14. Maiden Name —
15. Birthplace Va.

16 (a) Informant Elizabeth Hatchett
(b) Address 1532 N. Gilmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 26, 48 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Baltimore, Md.

18 (a) Funeral director Geo. E. Nelson
(b) Address 1303 Pennsylvania Ave.

19 (a) AUG 26 1948 (Date rec'd by registrar) (b) Huntington Maryland, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24, 1948, at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from August 23, 1948 to August 24 1948, and that I last saw him alive on August 24, 1948.

Immediate cause of death	Duration
Generalized tuberculosis	
Due to	
Due to	
Other Conditions Generalized tuberculosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Guy E Pegram Jr. M.D.
Address Baltimore City Hospitals Date signed 8/24/48

2000

VS 150

correct age is especially important. Physicians: please write the cause of death

66170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 66170

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not abbreviate. Give full name of city or county. If death occurred in hospital or institution, give its name instead of street and number. If non-resident, give city or county and state instead of street and number. If death occurred outside city or county in which decedent lived, give both places. Fill in all items. If unknown, or if not applicable, write "unknown" or "N. A." Physicians: please write the causes of death clearly and legibly, correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4258 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4258 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew J. Jones, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Helena E. Jones
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 187 4

8. AGE:	Years	Months	Days	If less than one day
	74	7	0	hr. min.

9. Birthplace Baltimore City, Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business retired

FATHER
12. Name Benjamin W. Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Jennings
15. Birthplace Maryland

16 (a) Informant Mrs. Helena E. Jones
(b) Address 4258 Falls Rd. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Messiah Lutheran
Location Berrett, CarrollCo. Md.

18 (a) Funeral director C. M. Waltz
(b) Address Winfield, Md.

AUG 26 1948 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948 at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Aug 1948 to 24 Aug 1948 and that I last saw ~~him~~ alive on 14 Aug 1948.

Immediate cause of death Arteriosclerotic Heart Disease — Duration 2 years

Due to Generalized Arteriosclerosis — 7 years

Due to

Other Conditions Malnutrition Severe — 2 mos
to generalparesis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mrs. Helena E. Jones
Address 2020 N Charles St Date signed 24 Aug 48

VS 150

666171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 666171

correct age is especially important. Physicians: please write the cause of death plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 945-W. Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) Country
(c) City or town Baltimore
(If not within city limits, state RURAL or INCORPORATED town)
(d) Street No. 945-W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Armiel Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-1877

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business ?

FATHER 12. Name ?
13. Birthplace Md.

MOTHER 14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant Leona Morgan
(b) Address 945-W. Fayette St.

17 (a) Burial (b) Date thereof 8/27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918-Lanvale St. Acting for William Boyd

19 (a) AUG 26 1948 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Aug 1948, at 1 A M

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy/Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Pelvis

Due to

Other Conditions Bronchial A.S. C.V. Disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 21 Aug at 10 18/1 A.M.
(b) Where did injury occur? 945-W. Fayette St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell from Window

23. Signature [illegible] M.D.
Medical Examiner

Date signed 22 Aug 48

G66172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 83a

Registered No. G66172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County Route 1
(c) City or town Odessa (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marjorie Nall (MARJORIE NALL)

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none
4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Adrian H. Nall
6 (c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.) 7-28-99
8. AGE: Years 49 | Months 0 | Days 27 | If less than 1 day: hr. min.
9. Birthplace: Fla. (Town, county, and state)
10. Usual Occupation: House wife
11. Industry or business:

FATHER
12. Name: Frank Bushnell
13. Birthplace: Minn.

MOTHER
14. Maiden Name: Alice Creelman
15. Birthplace: Canada

16 (a) Informant:
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/ /48 (month) (year)
(c) Cemetery or crematory: Dade City Cemetery
Location: Florida

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) AUG 26 1948 (Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1948, at 8 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1948 to 8/25 1948 and that I last saw h alive on 8/25 1948.

Immediate cause of death: Intracerebral Hemorrhage — Duration

Due to: Thrombocytopenic purpura, idiopathic

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Norman E Shaven M. D.
Address: JOHNS HOPKINS HOSPITAL Date signed 8-25-48

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G661173

G661173

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 51
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Culver

3 (b) If veteran, name war: Spanish American War
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Daniels
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1874

8. AGE: Years 74 | Months 5 6 | Days 19 | If less than one day: hr. min.

9. Birthplace Sweet Valley Water Town (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Levin Culver
13. Birthplace Tennessee

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Records
(b) Address US Marine Hospital, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 26 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) AUG 26 1948 (b) Huntington Williams, M.D.
(Date rec'd by Local Registrar) (Signature of Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 19 48, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 19 48 to August 21 19 48, and that I last saw h im alive on Aug. 21 19 48.

Immediate cause of death: Carcinoma of prostate with metastasis to left kidney and supra-
Due to clavicular nodes
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: Approximately 2 years

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 8-21-48

Correct age is especially important if deceased was under one year or one day

VS 150

6174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

Registered No. 666174

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Linden Ave.

(b) Street address 2402 Edmondson Ave.

(c) Hospital or institution: Maryland General Hospital 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days 23 years

(e) Length of stay in Baltimore (yrs., mos., or days) 23 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2402 Edmondson Ave
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katharine W. E. Lotz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~of wife~~ late Fredrick Lotz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 5, 1876

8. AGE: Years 72 | Months 7 | Days 12 | If less than one day hr. 18 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry C. Quental

FATHER 13. Birthplace France

MOTHER 14. Maiden Name Katherine Flatman

MOTHER 15. Birthplace Germany

16 (a) Informant F. W. Lotz

(b) Address 5312 Fern Park

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG 26 1948 (month) (day) (year)

(c) Cemetery or crematory LOUDON PK

Location 3801 FREDERICK AVE

18 (a) Funeral director Henry A. Wortzbe

(b) Address 4101 Edmondson Ave

AUG 26 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1948, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1948, to Aug 23 1948, and that I last saw her alive on Aug 23 1948.

Immediate cause of death: dissecting aneurysm abdominal aorta — Duration

Due to arteriosclerosis.

Due to

Other Conditions arteriosclerotic cardio vascular disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature Betty Mary Young M. D.

Address Maryland General Hospital Date signed 8/23

VS 15)

Please write plainly. Physicians: please write the cause of death clearly and report correct age is especially important.

G66175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G66175 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3658 Buena Vista Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 + 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3658 Buena Vista Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel E. Robertson.

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-07-3535

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Blanche P. Robertson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19, 1884

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Bartender
11. Industry or business Lockner's Cafe

FATHER
12. Name John W. Robertson.
13. Birthplace Maryland,

MOTHER
14. Maiden Name Anna Edwards.
15. Birthplace Maryland.

16 (a) Informant Blanche P. Robertson.
(b) Address 3658 Buena Vista Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27/48 (month) (day) year)

(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director Gustav E. Lonow
(b) Address 3638 Poland Ave.

19 (a) AUG 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24, 1948, at 11.30 p.m

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to Aug 24 1948.
and that I last saw him alive on Aug 24 1948

Immediate cause of death Cardiovascular Collapse — Duration 6 mo

Due to Coronary Occlusion — 10 yrs

Due to General Arteriosclerosis — 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert M. Fraley, M.D.
Address 2424 St. Paul St Date signed Aug 26-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G66176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 16+1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GLADYS CARTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	married

6 (b) Name of husband or wife William Carter.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1908

8. AGE: Years	Months	Days	If less than one day
39			hr. min.

9. Birthplace Lancaster County Virginia (Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER 12. Name Richard Jones.

13. Birthplace Lancaster County Va.

MOTHER 14. Maiden Name Addie Tompkins.

15. Birthplace Lancaster County, Va.

16 (a) Informant William Carter.

(b) Address 1315 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27, 1948 (month, day, year)

(c) Cemetery or crematory Heathsville Location Northumberland Co. Va.

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St

19 (a) AUG 26 1948 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1948, at 2.30a M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured Skull
Laceration of brain
Fracture of right humerus

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-23-48 at 1.30 a. M. In front of Campbell
(b) Where did injury occur? Cement Co., Route #40 nr. Whitemarsh
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury Trailer truck sideswiped auto

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed August 23, 1948

correct age is especially important. Physician: Please answer

X

66177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOROTHY CARTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1924

8. AGE: Years 24 | Months | Days | If less than one day hr. min.

9. Birthplace Lancaster County, Virginia (Town, county, and state)

10. Usual Occupation maid

11. Industry or business

FATHER 12. Name Joseph G. Carter.
13. Birthplace Lancaster County, Va.

MOTHER 14. Maiden Name Rachel Johnson.
15. Birthplace Lancaster County, Va.

16 (a) Informant: William Carter,
(b) Address 1315 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 27, 1948 (month, day, year)
(c) Cemetery or crematory Heathsville
Location Northumberland Co. Va.

18 (a) Funeral director Mrs. Nettie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) AUG 26 1948 (Date rec'd by registrar) Registrar for Williams, M.D.

VS 181

correct age is especially important; physician must write the

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1948, 2.30a.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushed chest
Pulmonary Hemorrhages of brain
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-23-48 at 1.30 a.M.
(b) Where did injury occur? in front of Campbell Cement Co., Route #40 nr. Whitemarsh
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury Trailer truck sideswiped auto

Signature George G. Merrill M.D. Medical Examiner.
Date signed August 23, 1948

66178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 66178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3917 REXMERE AVE.
(c) Hospital or institution: ******** ******
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 3917 REXMERE AVE. (If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT LANG

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-0133

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ELLA A. LANG
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) NOV. 14, 1876

8. AGE: Years	Months	Days	If less than one day
71	9	9	********* min.

9. Birthplace BALTIMORE MARYLAND (Town, county, and state)
10. Usual Occupation STEEL CLIPPER
11. Industry or business C.T. BRANDT CO.

FATHER
12. Name CHARLES LANG
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY LANG
15. Birthplace GERMANY

16 (a) Informant MRS. ELLA A. LANG (WIFE)
(b) Address 3917 REXMERE AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 26/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location BALTIMORE MARYLAND

18 (a) Funeral director F.B. WIPPERT & SON
(b) Address AUG 26 1948 2400 EUTAW PLACE. . 17

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 23rd. 1948 at 8;06 M P

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 12, 1945, to AUG. 23 1948.
and that I last saw h[im] alive on AUG. 23 1948

Immediate cause of death Coronary Thrombosis — Duration 1 hr.
Due to Hypertension Cardiovascular renal disease — 3 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Taylor M.D. M. D.
Address 3902 Greenmount Ave. Date signed

X

6179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. C66179

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 27-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4327 Harford Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Melfa

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-2441

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Carmela
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-28-1884

8. AGE: Years	Months	Days	If less than one day
63	7	28	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Francisco Melfa
13. Birthplace Italy

MOTHER
14. Maiden Name Libria Migliazzi
15. Birthplace Italy

16 (a) Informant Mr. Frank Melfa
(b) Address 2617 E. Oliver St.

17 (a) Burial (b) Date thereof 8-28-48
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Kuck
(b) Address 5305 Harford Rd.

19 (a) AUG 26 1948 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 19 48 at 1.37 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 19 48 to 8-25 19 48, and that I last saw him alive on 8-25 19 48

Immediate cause of death Cerebral hemmorrhage — Duration 1 day

Due to

Due to

Other Conditions Lobar pneumonia
Chronic alcoholic congestion
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: General Arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ann Powell, M.D.
Address Date signed 8-25-48

correct age is especially important. Physicians, please write plainly.

VS 150

8-30

6180

B-122250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 39c

Registered No. G66180

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4219 Erdman Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME B. Frank Kroeger

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 214-16-9629A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Bessie May Kroeger nee Reed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7- 1874

8. AGE: Years	Months	Days	If less than one day
74	5	17	hr. min.

9. Birthplace Md. (Balto.) (Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business Geo. P. Mahoney Co.

FATHER

12. Name Unknown

13. Birthplace "

MOTHER

14. Maiden Name "

15. Birthplace "

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/48 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) AUG 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24- 1948, at 3.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19- 1948 to 8-24- 1948 and that I last saw him alive on 8-24- 1948

Immediate cause of death: Probable Rocky Mountain Spotted Fever — Duration 10 days

Due to

Due to

Other Conditions Bronchopneumonia, left lung — 2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia, left lung

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature L. Steutzman M. D.

Address Balto. City Hosp. Date signed 8-25-48

correct age if especially large

VS 180

1785

G66181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 B

Registered No. G66181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town DUNDALK (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 Wise St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY KIOUSSIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife THEODORE

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) JUNE 18, 1911

8. AGE: Years	Months	Days	If less than one day
37	2	6	hr. min.

9. Birthplace MASSACHUSETTS (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name	PETER LOOMIS
FATHER 13. Birthplace	GREECE
MOTHER 14. Maiden Name	DESPINA THEODORES
MOTHER 15. Birthplace	GREECE

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8/28/48 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Windsor Mill Rd

18 (a) Funeral director Rambo & Hoffman
(b) Address 438-40 E. North Ave Huntington Williams, Mgr.

19 (a) AUG 26 1948 (Date received by Registrar)

VS 150 To be Approved by Medical Examiner

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948, at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1948, to 8-24 1948, and that I last saw her alive on 8-24 1948.

Immediate cause of death	Duration
Uremia	
Due to Renal failure	
Due to Bichloride of mercury poisoning	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? Suicide
(b) Date of occurrence 8-15-48 at 8 P M
(c) Where did injury occur? Baltimore, Balt. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify)
(e) Means of injury? Bich. Hg
Certificate to be made by Medical Examiner.
23. Signature John Colbert Harvey M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

66182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

✓ Registered No. 66182

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 West 40th St
(c) Hospital or institution:
Home for Incurables 13-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W 40th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sidney Belle Sutherland.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 27, 1872

8. AGE: Years 75 | Months 10 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John M. Sutherland
13. Birthplace Ireland.

MOTHER
14. Maiden Name Suzanna M. Michael
15. Birthplace Harford Co. Md.

16 (a) Informant Records of Home for Incurables
(b) Address 700 W. 40th St. Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John Mitchell & Son Inc.
(b) Address 2320 Eutaw Place

19 (a) AUG 26 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 1938 to 8/24 1948, and that I last saw her alive on 8/24 1948.

Immediate cause of death Hypertensive Cardio-Vascular Renal Disease — Duration 15 years
Due to
Due to
Other Conditions Atrophy of Legs secondary to Poliomyelitis — Duration 68 years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Grafton Hergerger M. D.
Address 214 Medical Arts Bldg Date signed 8/25/48

correct age is especially important. Physician, please write

VS 150

X

G66183

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 937

G66183
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 N. Eden St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 N. Eden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Ford

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1898

8. AGE: Years	Months	Days	If less than one day
49 50	10	24	hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Charles Ford
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Jackmond
15 Birthplace Va.

16 (a) Informant Rosetta Paige
(b) Address 1408 N Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A.A. County

18 (a) Funeral director McRoth & Ellwood Dyer
(b) Address 1129 N. Carlton St

19 (c) AUG 26 1948 (Date received by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Aug. 1948 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Aug 1948 to 23 Aug 1948 and that I last saw h er alive on 23 Aug. 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	6 mos.
Due to hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2305 Druid Hill Date signed 8-25-48

VS 150

correct ago is especially important. If uncertain, please write "about."

G666184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G666184

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3705 Egerton Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3705 Egerton Road (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 70 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Julius
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Samuel Scherr
(b) Address 3705 Egerton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philip Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2109 Gutaw St Baltimore, Md

19 (a) 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26- 1948, at 805 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1947 to Aug 26 1948 and that I last saw her alive on Aug 26 1948

Immediate cause of death: Coronary occlusion — Duration: 3 days
Due to: Coronary Heart Disease — 3 years
Due to: Senility
Other Conditions: Diabetes Mellitus (mild) Arteriosclerosis
(Include pregnancy within three months)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Wallenstein M. D.
Address 848 W Baltimore St Date signed 8/26/48

Correct age is especially important. Physicians, please write plainly.

VS 150

94a

AI-12236 G66185

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

G66185
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Democracy Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle Stella Jones

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Roy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 10--1885

8. AGE: Years 63 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name Thomas Rhodes
13. Birthplace Md.

MOTHER 14. Maiden Name ?
15. Birthplace Md?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28/48 (month) (day) (year)
(c) Cemetery or crematory Bel Air Burial Park
Location Bel Air, Md

18 (a) Funeral director Joseph T Fulton
(b) Address Bel Air Md

19 (a) AUG 2 1948 (b) Registrar Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948, at 1.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1948 to 8-26 1948, and that I last saw her alive on 8-26 1948.

Immediate cause of death Bronchopneumonia — Duration 2 days

Due to Cerebral Hemorrhage & right hemiparesis — 3 days

Due to Hypertensive-arteriosclerotic ? vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David H. Marcus M. D.
Address Balto City Hosps Date signed 8-26-48

correct age is especially important; copy name, place, and date plainly.

VE 1-3

G66186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

G66186
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1421 John street
(c) Hospital or institution:
14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 John street
(If rural give location)
(e) If foreign born, how long in U. S. A.? NO years

3 (a) FULL NAME Charles Hechter

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 52-0348-700 218-28-7511

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary E. Hechter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1879

8. AGE: Years 68 | Months 7 | Days 27 | If less than one day: hr. 20 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired Riding Instructor

11. Industry or business

FATHER
12. Name Henry Hechter
13. Birthplace Germany

MOTHER
14. Maiden Name Lena Kreutzer
15. Birthplace Germany

16 (a) Informant Mrs. Mary E. Hechter
(b) Address 1421 John street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Chas. J. Evans Son Inc
(b) Address 118 N. Mt Royal Ave.

19 (a) 8 26 1948 (Date rec'd by registrar) (b) Huntington Station Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1948, at 3.a.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945, to Aug 25 1948, and that I last saw h im alive on Aug 25 1948.

Immediate cause of death: Broncho-Pneumonia Bilateral — Duration 10 days

Due to:

Due to:

Other Conditions T.B. of Lt. Lung
Lumbar Vertebrae (X Ray J.H.H) — 2½ yr.
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Allen Deckert M.D.
Address 1114 St Paul St Date signed 8/25/48 (M. D.)

PLEASE WRITE PLAINLY, with ink or indelible pencil. Physicians: please write the causes of death clearly and correct age is especially important.

VS 8

61187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1216

Registered No. 666187

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Ruxton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank B. Adams (FRANK BLACKFORD ADAMS)

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 212-07-3255

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Mrs. Nancy Adams
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) July 12 1886

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	1	13		

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Executive V. Pres.
11. Industry or business Young & Selden Co

FATHER
12. Name Frank Blackford Adams
13. Birthplace Maryland

MOTHER
14. Maiden Name Caroline Blackford
15. Birthplace West Virginia

16 (a) Informant Wife
(b) Address Ruxton, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Henry W. Jenkins & Sons Co
(b) Address 4905 York Road

19 (a) AUG 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1948 at 1.25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1948 to August 25 1948, and that I last saw him alive on August 25 1948.

Immediate cause of death: Uremia — Duration: 25 days

Due to: Chronic glomerular nephritis — Duration: 1 year +

Due to:

Other Conditions: hypertension, cardio vascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. F. Cox 3rd M. D.
Address Union Memorial Hospital Date signed 8-26-48

VS 18.

66188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66188

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 53 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Conn. (b) County
(c) City or town Ridgefield (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 2 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM VALENTINE SJOVALL

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
--	--	M	W	Married

6 (b) Name of husband or wife Helen Sjovall
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 11, 1896

8. AGE: Years	Months	Days	If less than one day
52	4	13	hr. min.

9. Birthplace Brooklyn, NY (Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Seafarer

FATHER
12. Name Mathias Sjovall
13. Birthplace Finland

MOTHER
14. Maiden Name Ida ?
15 Birthplace Finland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30/48 (month) (day) (year)
(c) Cemetery or crematory
Location BRIDGEPORT, CONN.

18 (a) Funeral director Edgeworth Memorial
(b) Address 3911 Liberty Hgts. Ave

19 (a) [illegible] 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1948 to Aug. 24 1948, and that I last saw him alive on Aug. 24 1948.

	Duration
Immediate cause of death: Carcinoma, squamous cell, of left pyriform sinus with extension to epiglottis,	
Due to: base of tongue and right vocal cord with hemorrhage,	2 yrs.
Due to: Metastases to regional lymph nodes,	
Other Conditions: Obstruction, laryngeal partial and esophageal partial	1 6 mos.

(Include pregnancy within 3 months of death)
Date of operation: due to above
Major findings of operation:
of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 8/25/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

G66189 Registered No.

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Be sure to answer all questions correctly. Underline the cause to which death should be charged statistically. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2107 COLDSPRING LANE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
15
(d) Street No. 2107 COLDSPRING LANE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. EDWIN MORTIMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of ~~husband~~ wife GRACE B (BURNS)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 8 1857

8. AGE: Years	Months	Days	If less than one day
91	0	16	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name JOHN MORTIMER
13. Birthplace MD

MOTHER
14. Maiden Name ELIZABETH
15. Birthplace MD

16 (a) Informant MRS GLADYS M SEBASTIAN
(b) Address 3027 HARLEM AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 27 '48 (month) (day) (year)
(c) Cemetery or crematory OLIVET
Location ST MICHAELS MD

18 (a) Funeral director Harry H Wyble
(b) Address 401 Edmondson Ave

19 (a) (Date received by Registrar) (b) Registrar

Burlington for Waverly, Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 24 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from FEB. 1 1946, to August 19 48 and that I last saw h~~im~~ alive on Aug 24 19 48.

Immediate cause of death Chronic Glomerular Nephritis — Duration 10 yrs

Due to Arteriosclerosis — 15 yrs

Due to

Other Conditions Rt. Inguinal Hernia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman R. Kleiman M. D.
Address 3803 Edmondson Ave Date signed 8/26/48

G66190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G66190
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Lanbins Memorial Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Park Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Agnes Powers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex:	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1882

8. AGE: Years	Months	Days	If less than one day
66	1	0	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Director of Catholic Daughters

11. Industry or business

FATHER
12. Name Thomas J. Powers
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Morris
15. Birthplace Baltimore Md

16 (a) Informant Miss Kathleen Powers, Nephew
(b) Address Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meade and Son
(b) Address 805 N. Calvert Street
Huntington Williams, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1948 at 7:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1947 to Aug 25 1948 and that I last saw her alive on Aug 25 1948.

Immediate cause of death	Duration
Cerebral Embolism	
Due to Generalized carcinomatosis	
Carcinoma of breast	
Due to None	
Other Conditions Arteriosclerotic Cardiovascular Disease	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 1 Agnes Hosp Date signed 8/28/48

VS 150

X

G66191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824 W. Washington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 W. Washington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Zajic

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Zajic
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1881

8. AGE: Years 67 | Months 1 | Days 22 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation R.R. Watchman

11. Industry or business

FATHER
12. Name Jacob Zajic
13. Birthplace Bohemia

MOTHER
14. Maiden Name Katharine Sourbup
15. Birthplace Bohemia

16 (a) Informant Ella Oleska
(b) Address 827 W. Washington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Maryland
Location

18 (a) Funeral director Jerome Cvach
(b) Address 700 W. Chester St.

AUG 26 1948 (b) Washington Village
(Date rec'd by registrar) (Registrar) (Borough or district)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1948 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Aug 24 1948, and that I last saw h[illegible] alive on Aug 22 1948

Immediate cause of death: Coronary Artery Occlusion — Duration: [illegible]

Due to: Coronary Artery Disease — Duration: 2 yrs

Due to: Generalized Arteriosclerosis — Duration: ?

Other Conditions: Cerebral Hemorrhage. Hypertension Essential
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Bell M. D.
Address 1221 N. Luzerne Ave. Date signed Aug 25 1948

VS 150

6192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G66192
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2021 Eastern ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town 2021 Eastern Ave Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 Eastern ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Piorunski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Bronislaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Kijewski
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Andrew Dubert
(b) Address 519 S. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 (d) AUG 27 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1948 at 650 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 1 47 19 to Aug 26 1948 and that I last saw h alive on Aug 26 1948

Immediate cause of death	Duration
Coronary Thrombosis	Aug 26 '48
Due to Chr. Myocarditis	July 47
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William F. Kraus M.D.
Address 801 N Kenwood Ave Date signed 8/27/48

Please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

V 48 150

6193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G66193
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 N Clement St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Parsen Robert H W. Parsen

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elsie E Parsen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1900

8. AGE: Years	Months	Days	If less than one day
48	5	22	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Supply Clerk
11. Industry or business Monumental Life Ins Co

FATHER
12. Name Robert H. Parsen Sr
13. Birthplace Balto Md

MOTHER
14. Maiden Name Kathryn Brown
15. Birthplace Balto Md

16 (a) Informant Elsie E. Parsen
(b) Address 121 N Clement St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Aug 30 1948 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Balto Md

18 (a) Funeral director A. Raul Evans
(b) Address 1420 Sc Carey St

19 (a) AUG 27 1948 (Date rec'd by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26-48 19 , at 3 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18-48 19 , to 8-26-48 19 , and that I last saw h w alive on 8-26-48 19 .

Immediate cause of death	Duration
cardiac failure	
Due to myocardial storm	
Due to rheumatic heart disease & mitral stenosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan White M. D.
Address University Hosp. Date signed 8-26-48

VS 150

6194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G66194
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1123 Proctor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Proctor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Di Venti

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband: Joseph Di Venti
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 15 1886

8. AGE: Years 62 | Months - | Days 9 | If less than one day hr. min.

9. Birthplace Calascibetta Italy (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Stefano Passo
13. Birthplace Italy

MOTHER
14. Maiden Name Carmela Pedalino
15. Birthplace Italy

16 (a) Informant Joseph H Venti (Husband)
(b) Address 1123 Proctor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 27/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 322 S. High St.

19 (a) AUG 27 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27 1948, to 8/24 1948, and that I last saw h[illegible] alive on 8/24, 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: Sudden
Due to: Hypertension — ?
Due to:
Other Conditions: Bronchial Asthma
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

In person
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Joseph H. Venti
Address 1115 N. Calvert St. Date signed 8/24/48 M.D.

VS 190

G66195

BALTIMORE CITY HEALTH DEPARTMENT

G66195
Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospital 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5002 E. Eager Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDNA MUELLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Robt. A. Mueller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1900

8. AGE: Years 48 | Months 6 | Days 12 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wm. Parker
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Morris
15. Birthplace Md.

16 (a) Informant: Robt. A. Mueller
(b) Address 5002 E. Eager St.

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof Aug. 3/48 (month) (day) (year)
(c) Cemetery or crematory U.S. Natl. Cem.
Location Balto., Md.

18 (a) Funeral director Philip Hennig Sons
(b) Address 2024 Orleans St.

19 (a) AUG 7 1948 (Date received by registrar)
(b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1948, 10:30PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Artery Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature M.D.
Medical Examiner.
Date signed 6 Aug 48

correct age is especially important. Physicians, please

VS 151

G66196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G66196

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 Ellsworth Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R. Hogg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Stephen Hogg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 19, 1864

8. AGE: Years	Months	Days	If less than one day
84	5	7	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ---- Oliver
13. Birthplace Va.

MOTHER
14. Maiden Name Mrs. Thelma Franco
15. Birthplace 2121 Ellsworth St.

16 (a) Informant Mrs. Thelma Franco
(b) Address 2121 Ellsworth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto., Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) AUG 27 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 1948, at 1:20 A. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage,
Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mealeis M.D. Medical Examiner.
Date signed 8-26-48

VS 151

correct age is especially important. Physicians, please write the

X

G66197 G66137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 535 W. 40th St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 W. 40th St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3 (a) FULL NAME Oscar Mitchell Lemoine

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ruth Harlan
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) October 30, 1881

8. AGE: Years	Months	Days	If less than one day
66	9	26	..... hr. ..... min.

9. Birthplace Emmerton, Va. (Town, county, and state)
10. Usual Occupation Investment Banker, senior
11. Industry or business member of

FATHER
12. Name Oscar M. Lemoine
13. Birthplace Va.

MOTHER
14. Maiden Name Maria Braxton
15. Birthplace Va.

16 (a) Informant Mrs. Ruth H. Lemoine
(b) Address 535 W. 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave. Balto.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) ..... 1948 ..... (Date filed by registrar) Registrar ..... Address .....

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1948, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1948 to Aug. 25 1948. and that I last saw h[illegible] alive on Aug. 23 1948.

Immediate cause of death Cerebral hemorrhage.

Due to Arteriosclerosis

Due to .....

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature John H. Jenkins M. D.
Address 1035 N. Calvert St. Date signed

V3 153

666198 ES122320

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

666198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals. 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1345 James St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Maggie Marie Oster

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife Frederick J. Oster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 7, 1877

8. AGE: Years	Months	Days	If less than one day
72	7	17	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Brooks (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie Rodgers (D)
15. Birthplace ?

16 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 27 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick T. Cole
(b) Address 1946 W. Lombard St

19 (a) (b) Timberlake Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24 1948 at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23 1948 to 8-24 1948 and that I last saw her alive on 8-24 1948

Immediate cause of death Cardiac failure — Duration 4 days.

Due to Coronary occlusion probable.

Due to Coronary atherosclerosis

Other Conditions cerebral vascular accident questionable.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David H. Guarnieri M.D.
Address Balto City Hosp Date signed 8-29-48

correct age is especially important.

VS 150

G66[illegible]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66[illegible]

555

1. PLACE OF DEATH:
(a) Baltimore City or Maryland
(b) Street address, No. 508 Riverside Road
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto Co.
(c) City or town Essex
(If outside city or town limits, write RURAL and give name)
(d) Street No. 508 Riverside Drive
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Dumeier

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jacob Dumeier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 5 1884

8. AGE: Years 64 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation:

11. Industry or business: At Home

FATHER
12. Name: H. H. Sauer
13. Birthplace: Germany

MOTHER
14. Maiden Name: Dorothy Brandau
15. Birthplace: Germany

16 (a) Informant: Jacob Dumeier
(b) Address: 508 Riverside Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: City

18 (c) Funeral director: Ulrich Funeral Home
(b) Address: 2004 Orleans St

19 (a) [illegible] (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 25 1948, at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1948 to Aug 25 1948, and that I last saw her alive on Aug 25 1948.

Immediate cause of death: Cancer - generalized Carcinomatosis

Duration: /

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

over

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Roger Straub M. D.

Address: Date signed Aug 25 48

VS 150

X

G6b-450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937 (Revised)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 407 N. Robinson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 N. Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Kirtscher

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Clara Kirtscher
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept 24 1880

8. AGE: Years	Months	Days	If less than one day
67	10	26	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation City Parks
11. Industry or business General

FATHER
12. Name Frank Kirtscher
13. Birthplace Germany

MOTHER
14. Maiden Name Dont know
15. Birthplace Germany

16 (a) Informant Clara Kirtscher
(b) Address 407 N. Robinsen

17 (a) Remove (Burial, cremation, or removal) (b) Date thereof Aug 28 (month) (day) (year)
(c) Cemetery or crematory Baltimore City
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2026 Bleam St

19 (a) AUG 27 1948 (Date rec'd by registrar) (b) Wilmington, Del. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22 1948 at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1948 to Aug 22 1948 and that I last saw him alive on 8-22 1948.

Immediate cause of death	Duration
Myocardosis	?
Due to Hypertensive cardio vascular disease	?
Due to	
Other Conditions Arteriosclerosis.	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J Gould M.D.
Address 147 N. East Ave Date signed 8-25 1948

Correct age is especially important. Physician: please write the cause of death very plainly.

VS 150

G66201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

928

G66201 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RHODA J. MASON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 13, 1869

8. AGE: Years 78 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Mitchell
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Miss Marie Mason
(b) Address 1819 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) AUG 1948 (Date rec'd by registrar) (b) Filed by Wm. M. [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1948 at 2:45 M

21. I certify that death occurred on the date above stated, and attended deceased from June 18 1948 to Aug 24 1948 and that I last saw her alive on Aug 24 1948.

Immediate cause of death

Due to Mitral Insufficiency

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration
?
L

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. B. Hughes M.D.
Address 1413 Druid Hill Ave Date signed Aug 26/48

correct age is especially important. Physicians: please write the causes of death clearly for registry.

V-2 150

202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66202
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 McElderry St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leontine Geasford

3 (b) If veteran, name war: No

3 (c) Social Security Account No: 213-01-3954

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife: Harry J. Geasford
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1882

8. AGE: Years	Months	Days	If less than one day
65 66	11	25 24	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Housewife Operator
11. Industry or business Wm. Willner & Sons

FATHER
12. Name Charles L. Kidd
13. Birthplace Charleston, South Carolina

MOTHER
14. Maiden Name Lena Platt
15. Birthplace Charleston, South Carolina

16 (a) Informant Husband Mr. J. Harry Geasford
(b) Address 2310 McElderry Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 AUG 27 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 August 25. 1948, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Aug 48 19 . to 25 Aug 19 48, and that I last saw her alive on 25 Aug 1948.

Immediate cause of death Congestive Heart Failure — Duration 9 days

Due to Syphilitic Aortitis with Aortic Insufficiency

Due to

Other Conditions Terminal anuria with uremia — 4 days
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy Permission refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald L. England M.D.
Address Maryland General Hospital Date signed 25 Aug 48

correct age is especially important. Physicians, please write the cause of death plainly.

VS 153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G66203

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2019 E. 32nd. Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 E. 32nd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSABELLE MOENIUS

3 (b) If veteran, name war: No
3 (c) Social Security Account: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward Moenius
6 (c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Dec. 30, 1891

8. AGE: Years: 56 | Months: 7 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Norfolk, Va.
(Town, county and state)

10. Usual Occupation: Housewife
11. Industry or business

Parents
12. Name: James W. Pennie
13. Birthplace: Baltimore, Md.

Parents
14. Maiden Name: Isabella C. Pedman
15. Birthplace: Maryland

16 (a) Informant: Mrs. Isabella Tunis
(b) Address: 2019 E. 32nd. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/48 (month) (day) (year)
(c) Cemetery or crematory: Mount Carmel
Location: Baltimore

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 AUG 27 1948 (Date rec'd by registrar) (b) Washington Boulevard

MEDICAL CERTIFICATION

A

20. DATE OF DEATH August 25 1948, at 10.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1948 to 8/25 1948, and that I last saw her alive on 8/24 1948.

Immediate cause of death: Abdominal carcinoma — Duration: 6 mos.

Due to: —

Due to: — over

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Willis Guyton, M.D.
Address 3963 Greenmount Ave Date signed 8/25/48

correct are is especially important. Physicians: please write the cause of death clearly with ink.

VS 190

6204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. 666204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3029 Mayfield Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md, (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3029 Mayfield Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY REESE FEHLEY

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-05-4932

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna C. Fehley

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 23, 1887

8. AGE: Years 31 | Months 4 3 | Days 0 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation watchman

11. Industry or business Bozman Bros.

FATHER
12. Name George W. Fehle
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Warner
15. Birthplace Ill.

16 (a) Informant Mrs Edna C. Fehle
(b) Address 3029 Mayfield Avenue - 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Baltimore, Md,

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

AUG 27 1948 (Date rec'd by registrar)

(b) [illegible] Registrar

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 3.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 1 1948 to AUG 26 1948 and that I last saw him alive on Aug 26 1948

Immediate cause of death: Carcinoma urinary bladder — Duration: 6 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation April 48

Findings of operation: Carcinoma bladder

PHYSICIAN: Underline the cause to which death should be charged statistically.

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Fritz S Kimzey M.D.

Address 7700 Harford Rd Date signed 8/26/48 M.D.

X

CERTIFICATE CORRECTED 9-1-60

6205
BF-102003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66205

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Formerly at
(d) Street No. 1148 Longwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas B. Clary

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Clara B. Clary

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Aug. 27-1871

8. AGE: Years 76 | Months 11 | Days 29 | If less than one day: hr. min.

9. Birthplace Md. (Balto.)
(Town, county, and state)

10. Usual Occupation ? Retired

11. Industry or business G.

FATHER
12. Name Richard Clary
13. Birthplace ? Maryland

MOTHER
14. Maiden Name Clementine Brashears
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 27 1948 (Date rec'd by registrar) (b) Signature for Wilhelmina Mc Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948, at 12. AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-12- 1948 to 8-25-26 1948.
and that I last saw h im alive on 8-25-26 1948.

Immediate cause of death: Bronchopneumonia, bilat.

Due to Generalized coronary arteriosclerosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Vickery M. D.
Address Balto City Hosp. Date signed Aug 4.

correct age is especially important. Physicians, please write

VS 130

6206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 13B

G66206 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1919 W Franklin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 W Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward T Fell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 3rd 1898

8. AGE: Years 50 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Bar Tender

11. Industry or business

FATHER 12. Name John Fell
13. Birthplace Md

MOTHER 14. Maiden Name Lena Schanberger
15. Birthplace Md

16 (a) Informant Mrs. Rose V. Fell
(b) Address 1919 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 / 30 / 48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St

AUG 27 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27th 1948 at 12 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Aug 27 1948
and that I last saw h alive on July 1948

Immediate cause of death

	Duration
Pulmonary Tuberculosis	8 yrs.
Due to	
Due to	
Other Conditions Laryngeal Tuberculosis	8 yrs.

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence M. Lena M.D.
Address 11E Chase St Date signed 8/27/48

correct age is especially important. Physicians: please write the cause of death in plain English—avoid abbreviations.

VS 150

6207 G666207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6513

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 N. Catherine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Lawrence Riley

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-4687

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marion (Marking)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/23/02

8. AGE: Years	Months	Days	If less than one day
45	11	1	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Operator
11. Industry or business Baltimore Transit Company

FATHER
12. Name JOHN RILEY
13. Birthplace MD

MOTHER
14. Maiden Name ELIZABETH ECKMAN
15 Birthplace MD.

16 (a) Informant MRS MARION RILEY
(b) Address 9 N. CATHERINE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 28 '48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE

18 (a) Funeral director Nancy A. Zeigler
(b) Address 908 Edmondson Ave

19 AUG 27 1948 (Date rec'd by Registrar) (Name) Hampton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24, 1948, at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20, 1948 to Aug. 24, 1948, and that I last saw him alive on Aug. 24, 1948.

Immediate cause of death Generalized toxemia — Duration
Due to Adrenal insufficiency
Due to Generalized exfoliative dermatitis
Other Conditions GENERALIZED EXFOLIATIVE DERMATITIS
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Adrenal destruction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ray E. Parsons Jr. M.D.
Address St. Joseph's Hosp. Date signed 8/24/48

VS 130

3208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. 666208

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 122 N Hollins St
(c) Hospital or institution: 18

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 N Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie L. Travers (Mary L. Travers)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	widow

6 (b) Name of husband or wife late Edward W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1875

8. AGE: Years	Months	Days	If less than one day
73	3	14	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James D. Glorsuch
13. Birthplace Md

MOTHER
14. Maiden Name Mattie B. Thompson
15. Birthplace Md

16 (a) Informant Alice Whitney
(b) Address 1210 Hollins St

17 (a) Burial (b) Date thereof Aug 27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry H. Fitzke
(b) Address 401 E Lanvale Ave.

19 (a) AUG 27 1948
(Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1948 at 1:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Aug 25 1948. and that I last saw h[illegible] alive on Aug 24 1948.

Immediate cause of death	Duration
Arteriosclerosis	
Due to Pneumonia	
Due to Mitral Stenosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. Kalaris M.D.

Address 24 N. Fremont Ave Date signed 8/26/48

correct age is especially important. Physicians: please write the cause of death plainly. See p.

6209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G66209

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 Lake Drive
(c) Hospital or institution: 13-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 Lake Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry O. Slusky

3 (b) If veteran, name war World I

3 (c) Social Security Account No. 214-03-5902

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rea Bernstein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 15 1890

8. AGE: Years 58 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Insurance Salesman

11. Industry or business

FATHER
12. Name Felix Slusky
13. Birthplace Russia

MOTHER
14. Maiden Name Ida Selenkow
15. Birthplace Russia

16 (a) Informant Mrs. Rea Slusky
(b) Address 823 Lake Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) Aug (day) 29 (year) 48
(c) Cemetery or crematory Arlington
Location Rogers Ave.

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1126 W. North Ave.

AUG 27 1948 (Date rec'd by registrar)

Transcribed for Williams, M.D.

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1948 to Aug 27 1948 and that I last saw h[illegible] alive on Aug 23 1948.

Immediate cause of death Hypertensive Cardiovascular Disease

Duration 2 Yrs 2 Yrs

Due to Cerebral Hemorrhage

Duration 1 minute

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A A Weinstock M. D.

Address 4603 Park Heights Ave Date signed 8/27/48

correct age is essential for accurate statistics

666210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 666210

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Green Sts

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1112 S. Carey St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Charles Kerr

3 (b) If veteran, name war

3 (c) Social Security Account No. 205-10-1804

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Grace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/3/1884

8. AGE: Years	Months	Days	If less than one day
61	11	21	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation General Foreman

11. Industry or business B & O R.R.

FATHER 12. Name John E.

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Mary Susan

MOTHER 15. Birthplace Md.

16 (a) Informant Mrs. Charles F. Kerr

(b) Address 1112 S. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 27, 1948 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Witzke

(b) Address 4101 Edmondson ave.

19 (a) AUG 27 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948 at 2058 M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19— , to — 19— ,

and that I last saw h — alive on — 19— .

Immediate cause of death — Coronary occlusion — Duration

Due to Coronary Artery Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature David B Barnes M.D.

Address Univ. Hosp. Date signed 8-27-48

VS 150 Subject to Release by Medical Examiner Edmond J. Mellon, M.D.

866211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 866211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3913 Farrington Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3913 Farrington Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Silverman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Israel Gerber
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Mrs James Fink
(b) Address 3913 Farrington Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Levy Inc
(b) Address 2400 Eutaw Place

19 (a) AUG 27 1948 (Date rec'd by reg.) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26- 1948 at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1948 to 8/26 1948; and that I last saw her alive on 8/26 1948.

Immediate cause of death Carcinoma of Stomach. Duration 6 mo

Due to

Due to

Other Conditions Carcinoma of Breast (Include pregnancy within 3 months of death) 5 mo.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irvin S. Cohen M.D.
Address 115 N. Calvert St Date signed 8/31/48

VS 150

666212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 666212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4224 Kelway Rd
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or ~~town~~ Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4224 Kelway Road
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME JOSEPHINE BODGE SIBLEY

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Fem.

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or divorced: widow

6 (b) Name of husband or ~~wife~~: George L. Sibley

6 (c) If wife, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 14, 1861

8. AGE: Years: 87 | Months: 0 | Days: 12 | If less than one day: ____ hr. ____ min.

9. Birthplace: Weymouth, Mass
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: George Bodge
13. Birthplace: Needham, Mass.

MOTHER
14. Maiden Name: Mary Chandler
15. Birthplace: Boston, Mass

16 (a) Informant: Mr. George N. Sibley
(b) Address: 4224 Kelway Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-28-48 (month) (day) (year)
(c) Cemetery or ~~crematory~~: Ridgelawn
Location: Watertown, Mass.

18 (a) Funeral director: Wm J. Tickner & Sons.
(b) Address: North & Pa. Aves.

19 (a) AUG 27 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948, at 9 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1948, to Aug 26 1948, and that I last saw h— alive on Aug. 26 1948

Immediate cause of death: Arteriosclerotic heart disease

Duration: Years.

Due to

Due to

Other Conditions: Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 701 E. Preston St. Date signed 8/27/48

correct age is especially important. Physicians, please write plainly.

VS 150

937

G66213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G66213

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 N. CAROLINE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 7
(e) Length of stay in Baltimore (yrs., mos., or days) 30 7 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 N. CAROLINE ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) FULL NAME MARIE GAINES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	WIDOW

6 (b) Name of husband or wife ALEXANDER
6 (c) If alive, give age (D) years

7. Birth date of deceased (mo., day, yr.) JAN. 2, 1883

8. AGE: Years	Months	Days	If less than one day hr.	min.
65	7	23		

9. Birthplace WASH. D.C. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name ?
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace Md

16 (a) Informant SINTHIA SMITH
(b) Address 1613 BARNES

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-28-48 (month) (day) (year)
(c) Cemetery or crematory MT. CALVRY
Location A.A. County, Md.

18 (a) Funeral director Joseph B. Locke
(b) Address 1324 N. Carrollton

19 AUG 27 1948 (Date rec'd by registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 1948 at 5:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7 1948 to 8/25 1948 and that I last saw h-r alive on 8/24/1948

Immediate cause of death: Carcinoma of Stomach — Duration: 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature RAYNER BROWNE, M.D. Date signed 8/27/48

Address 1501 EAST MADISON ST. BALTIMORE 5, MD.

VS 150

PRESS WHITE PAPER FIRMLY. Please write the causes of death clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 66214

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 Quantril Ave., Armstead
(c) Hospital or institution: Gardens

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Quantril Ave., Armstead Gard.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph AMOR KREIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1879

8. AGE: Years 69 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Houchens Medicine Co.

FATHER
12. Name Francis Krein
13. Birthplace Md.

MOTHER
14. Maiden Name Anna (Unknown)
15. Birthplace Md.

16 (a) Informant Catherine M. Houchens
(b) Address 5 Ray Northgate Rd. Northwood

17 (a) Burial Burial, cremation, or removal (b) Date thereof 8/31/48 (mo.) (day) (yr.)

(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director Milton Colvin
(b) Address 1341 Light St

19 (a) AUG 27 1948 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948 10:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8/25/48

VS 151

correct age is especially important. Physicians, please write plainly.

666215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 666215

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 W Lond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Magnus B. Milner

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Rosalie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12 1874

8. AGE: Years 73 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Farmersville Pa (Town, county, and state)

10. Usual Occupation Dentist

11. Industry or business

FATHER 12. Name John B Polk Milner

13. Birthplace Pa

MOTHER 14. Maiden Name Susie A Aurora

15. Birthplace Ga

16 (a) Informant Thomas H Orth

(b) Address Chesnut Hill Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 28 48 (month) (day) (year)

(c) Cemetery or crematory Lindenwood

Location Ephrata Pa

18 (a) Funeral director Wilson & Long

(b) Address 1217 Eutaw St

19 (a) AUG 27 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 1948, at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Heart Disease

Due to Generalized Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert B. McFadden M.D. Medical Examiner.

Date signed 8-26-48

66216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 66216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 McCabe Ave
(c) Hospital or institution: None 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County None
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 McCabe Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Josephine D. Hermann

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife Charles H.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 27, 1871

8. AGE: Years 76 | Months 8 | Days 29 | If less than one day hr. — min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER 12. Name Augustus W. Deiss
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Josephine Rosenstiel
15. Birthplace Baltimore Md.

16 (a) Informant Eugene V. Hermann
(b) Address 600 McCabe Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Highlawn Md

18 (a) Funeral director Wilson & Dodge
(b) Address 5411 Park Ave

19 (a) AUG 29 1948 (Date) rec'd by registrar Counter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 August 1948 at 1027 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 25 Aug 1948 to 26 Aug 1948, and that I last saw h[illegible] alive on 25 Aug 1948.

Immediate cause of death
a Cerebral Hemorrhage — Duration 9 days
Due to Hypertension — 8 mos.
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury —

23. Signature John A. Osborne M.D.
Address 560 Wendover Rd Date signed 26 Aug 48

VS 150

FORM—Write plainly with pen or indelible pencil. Physicians: please write the causes of death clearly and correct age is especially important.

G66217 J1- 122377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G66217

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 S. Catherine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May Mays

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 9, 1877

8. AGE: Years	Months	Days	If less than one day
71	3 4	16	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Mays
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Martin
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Middletown
Location Baltimore Co. Md.

18 (a) Funeral director Mahoney & Son
(b) Address 1210 Fort St

19 (a) AUG 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1948 at 7.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 24 1948 to Aug. 25 1948, and that I last saw h or alive on Aug. 25 1948.

Immediate cause of death Peritoneal shock ? — Duration 6 hrs

Due to Ovarian carcinoma probable.

Due to

Other Conditions Arteriosclerotic Heart disease & Ulcers
(Include pregnancy within 3 months of death)

Date of operation 8-25-48

Major findings of operation: Paracentesis - bloody ascitic fluid.

of autopsy: not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David N. Marcus M. D.
Address Balto City Hosp Date signed 8-26-48

66218
1B 78395

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. 66218

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 7-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 8 22 5yr. 8mo. 22days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
4 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Horace Leash

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Grace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1871

8. AGE: Years	Months	Days	If less than one day
77 (71) 77	3	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Leash (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Lucy Penn (D)
15. Birthplace Md.

16 (a) Informant Melva Covalier
(b) Address 2163 Kennedy Ave
17 (a) Final (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md
18 (a) Funeral director Wilbur C. Lee
(b) Address 1217 E. Pratt St
19 (a) AUG 27 1948 (Date rec'd by registrar) (b) Burington Williamsburg Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 1948 at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4 1942 to 8-26 1948, and that I last saw h im alive on 8-26 1948

Immediate cause of death Pulmonary edema

Due to Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Nicholas M. D.
Address Balto City Hosp Date signed 26 Aug 48

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66219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. 666219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 S. Belnord ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Maciolek

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/91

8. AGE: Years 57 | Months 5 | Days 07 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Crane operator

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name Anna —
15. Birthplace Poland

16 (a) Informant Mrs Helen Maciolek
(b) Address 815 S Belnord ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30-48 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md

18 (a) Funeral director John J Dada
(b) Address 2829 Nelson St

19 (a) AUG 27 1948 (Filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 1948 at 1:45 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 8/24 1948 to 8/26 1948 and that I last saw him alive on 8/26 1948.

Immediate cause of death: Hemorrhage from liver — Duration

Due to metastatic carcinoma

Due to primary carcinoma of middle 1/3 of esophagus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Not stated

of autopsy: other

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles J. Blazek
Address Maryland General Hospital Date signed 8/26/48

VS 150

correct age is especially important. Physicians, please write plainly.

G66220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G66220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3420 Edmondson Ave.
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME M. Estelle Welty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Widow

6 (b) Name of husband or wife late Joseph D. Welty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1865

8. AGE	Years	Months	Days	If less than one day
	82	9	7	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Spalding
13. Birthplace Md.

MOTHER
14. Maiden Name Taylor
15. Birthplace Md.

16 (a) Informant Mrs. Mary Zaruba
(b) Address 3420 Edmondson Ave.

17 (a) Burial (b) Date thereof Aug. 30/48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Emmittsburg, Md.

18 (a) Funeral director Harry H. Weitzle.
(b) Address 4101 Edmondson Ave.

19 AUG 27 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26/48 19 , at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 46 to 8/26 1948
and that I last saw h alive on 8/25 19 48

Immediate cause of death
Acute Cardiac Failure — Duration 1 day

Due to Arteriosclerotic
Cardiovascular Disease — Duration 2+ Yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 3629 Edmondson Date signed 8/26/48

Correct age is especially important. Physicians: please write the cause of death clearly and fully.

VS 100

6221 — 666221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution:
General German Aged Peoples Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Ott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late Bertha Ott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1865

8. AGE: Years 83 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William J. Ott
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ----------
15. Birthplace Germany

16 (a) Informant Mr. J. George Wals,
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28/48 (month) (day) (year)
(c) Cemetery or crematory 1st German United Luth. Evan. Church
Location 6115 O'Donnell St.

18 (a) Funeral director Henry H. Lutze
(b) Address 4101 Edmondson Ave.

19 (a) AUG 27 1948 (Date rec'd by registrar) (b) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26/48. 19 , at 5.30 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15/48 19 Aug. 26/48 , and that I last saw him alive on Aug. 20/48.

Immediate cause of death	Duration
Chronic Cardiac Dilitation.	Unknown.
Due to	
Due to	Unknown.
Other Conditions Arterio Sclerosis.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Waldo Coburn M. D.
Address 933 Hanover St. Date signed Aug 27/48.

Waldo Coburn M.D.

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Physicians: please write the causes of death clearly and correctly. Accuracy in stating age is especially important.

G66222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G66222 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution:
House in the Pines Nursing Home 20/3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Wilhelm St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna R. Ritter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank E. Ritter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1889

8. AGE: Years 58 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wm. A. Carroll
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Tydings
15. Birthplace Md.

16 (a) Informant Frank E. Ritter
(b) Address 2003 Wilhelm St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28/48. (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Weitzle
(b) Address 4101 Edmondson Ave.

19 (a) Date rec'd by Local Registrar (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25/48. 19 at 2 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/13 19 48 to 8/25 19 48 and that I last saw her alive on 8/24 19 48.

Immediate cause of death Carcinoma, left ovary — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert H. Katz M. D.
Address 4020 Watkins Ave. Date signed 8/27/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G66223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 59 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1826 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: JOHN ROLAND STEVENS

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: ?

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edytha Stevens
6 (c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Nov. 1, 1889

8. AGE: Years: 56 | Months: 9 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Rock Hall, Md. (Town, county, and state)
10. Usual Occupation: Quartermaster
11. Industry or business: Seafarer

FATHER
12. Name: John T. Stevens
13. Birthplace: Md.

MOTHER
14. Maiden Name: Emma A. Davis
15. Birthplace: Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 30-48 (month) (day) (year)
(c) Cemetery or crematory: Wesley Chapel
Location: Brooklyn Park, Md.

18 (a) Funeral director: Edgar L Lane
(b) Address: Rock Hall Md

19 (a) [illegible] (Local Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 27 1948, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1948 to Aug. 27 1948, and that I last saw him alive on Aug. 27 1948.

	Duration
Immediate cause of death: Carcinoma, bronchogenic, left upper lobe with metastases to regional lymph	
Due to: nodes, liver & kidneys	4 mos.
Due to:	
Other Conditions: Bronchiectasis, left lower lobe	Several months

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed 8/27/48

V S 190

correct age in especially important. Physicians: please write the cause of death clearly and legibly.

66224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G66224 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Queen Anne
(c) City or town Centreville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Clark Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1897

8. AGE: Years 51 | Months | Days | If less than one day: hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER 12. Name: Henry Furbush

13. Birthplace: Md

MOTHER 14. Maiden Name: Annie Lucas

15. Birthplace: Md

16 (a) Informant: Hosp

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30-48 (month) (day) (year)

(c) Cemetery or crematory: Church Hill

Location: Church Hill Md

18 (a) Funeral director: Edgar L Lane

(b) Address: Church Hill Md

19 (a) AUG 28 1948 (Date received by Registrar) Huntingtown Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27 1948 at 10:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1948 to 8-27 1948 and that I last saw h.e.r. alive on 8-27 1948.

Immediate cause of death: cardiorespiratory arrest

Due to: peritonitis

Due to: carcinoma of sigmoid colon

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-14-48

Major findings of operation: carcinoma of sigmoid colon

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature: John S. Lowery M. D.

Address: University Hosp. Balto 1 Md Date signed 8-27-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G662225

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 640 E. 28th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Graves

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Sep.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-13-22

8. AGE: Years 26 | Months - | Days 10 | If less than one day hr. min.

9. Birthplace So. Carolina (Town, county, and state)

10. Usual Occupation Farm work

11. Industry or business

FATHER
12. Name Benton Graves
13. Birthplace So. Carolina

MOTHER
14. Maiden Name Mary C. Morrison
15. Birthplace So Carolina

16 (a) Informant:
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Aug 27 48 (month) (day) (year)
(c) Cemetery or crematory
Location Bennettsville S. C.

18 (a) Funeral director Holland Funeral Home
(b) Address 6 W Lexington Hill Ave

19 (a) AUG 28 1948 (Date rec'd by registrar) (b) Undertaker for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1948 to 8/23 1948, and that I last saw h[illegible] alive on 8/23 1948.

Immediate cause of death Congestive heart failure. — Duration weeks.

Due to Cardiac hypertrophy and dilitation. — months or years.

Due to Hypertension, Chr. nephritis — years.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Chr. nephritis, hyperten[illegible] cardiac enlargement clinically.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Carolyn J. Epps M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 8-25-48

VS 150

666226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 666226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1918 Kennedy Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 Kennedy Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lydia A. Broomhead

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Robert C. Broomhead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1858

8. AGE: Years 90 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Daniel Hammel
13. Birthplace Penna

MOTHER 14. Maiden Name Katherine Hyde
15 Birthplace Penna

16 (a) Informant Zora E. Hammel
(b) Address 1918 Kennedy Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-48 (month) (day) (year)

(c) Cemetery or crematory Harrisburg Cem
Location Harrisburg, Penna.

18 (a) Funeral director John A. Moran
(b) Address 3000 E. Balt. St.

1948 AUG 28 1948 Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948, at 6.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1947 to Aug 26 1948 and that I last saw her alive on Aug 25 1948.

Immediate cause of death: Diabetes mellitus
Hypertension — Duration 1 yr

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Harry Hyde M. D.
Address Date signed

V3 150

Tucker

A366227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

176

Registered No. 366227

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos 17 da
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos 17 da

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Washington
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Rodney Tucker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day: hr.	min.
43				

9. Birthplace maryland (town, county, and state)

10. Usual Occupation machine operator

11. Industry or business K & S Pipebod Co 10 Foundry St, Hagerstown

FATHER 12. Name Thomas A. Tucker
13. Birthplace md

MOTHER 14. Maiden Name Martha E. Gross
15. Birthplace md.

16 (a) Informant Rita Faubl
(b) Address Hyattsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27 1948 (month) (day) (year)
(c) Cemetery or crematory Lutheran
Location Mount Gove Md

18 (a) Funeral director C. W. Foster Bro
(b) Address Brunswick Md

19 (a) AUG 23 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948 at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948 to Aug 1 1948 and that I last saw him alive on July 30 1948 approx.

Immediate cause of death	Respiratory Arrest	Duration
Due to	Internal hydrocephalus	2 mos 1 wk
Due to	Adhesive arachnoiditis	2 mos 1 wk
Other Conditions	Pneumonia, Hypostatic, Bilateral, Fracture of Right Femur	5½ mos

Brain surgery (Major) (Minor)
Date of operation May 11, 21, June 2, 48
Major findings of operation: Adhesive arachnoiditis
of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence March 8, 1948 at M
(c) Where did injury occur? Hagerstown, Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? K & S Pipewood Co N Foundry St (Specify) While at work? yes
(e) Means of injury Left arm caught in wheel

23. Signature J. R. Hankins
Address Univ Hospital Date signed 8/27 M. D.

Corpse by H. J. Mullins, M.C. Death due indirectly to external causes, in that basilar skull fracture

VS 190

666228

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

666228 Registered No. 1220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Streets
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County —
(c) City or town Greencastle (If outside city or town limits, write RURAL, and give town)
(d) Street No. 162 North Allison Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) FULL NAME Elsie Jean Lucille Mellinger
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 24, 1926
8. AGE: Years 22 | Months 3 | Days 34 | If less than one day — hr. — min.
9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation clerical
11. Industry or business

FATHER 12. Name Elmer Mellinger
13. Birthplace Penna

MOTHER 14. Maiden Name Bessie M. Shatzer
15. Birthplace Penna

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 28 48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Greencastle Pa.

18 (a) Funeral director J. H. Lehmer & Sons
(b) Address Williamsport, Washington Co., Maryland

19 (a) AUG 28 1948 Huntington for Williamsport, Md. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 12 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1948 to Aug 28 1948 and that I last saw h[illegible] alive on Aug 28 1948.

Immediate cause of death	Duration
acute respiratory failure	30 min
Due to bronchial constriction	30 min
Due to drug sensitivity	
Other Conditions recent lumbar spinal fusion (Include pregnancy within 3 months of death)	

Date of operation 8-23-48
Major findings of operation: Ruptured post-sacral [illegible] Ruptured d.c.
See Lumbar surgeons
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) [illegible]te of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M. Clausen
Address Union Memorial Hosp. Date signed 8/28/48 (M) (D)

666229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183B

Registered No. 666229

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eaton Ave
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Rosson Hotel, 512 York Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William R Hughes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 1880

8. AGE: Years 68 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Liverpool England (Town, county, and state)

10. Usual Occupation Engraver

11. Industry or business Gen Engraver

FATHER 12. Name James Hughes
13. Birthplace England

MOTHER 14. Maiden Name Martha Clements
15. Birthplace England

16 (a) Informant Phillip Hughes
(b) Address 722 E 21st St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Md

18 (a) Funeral director Milligan & Colvin
(b) Address 1214 N

19 [redacted] (b) [redacted] for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948, at 12 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1948, to Aug 27 1948 and that I last saw h[illegible] alive on Aug 23 1948.

Immediate cause of death: Cerebral thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack J Dingle M. D.
Address 506 E North Ave Date signed 8-27-48

correct age is especially important. Physicians: please write out the cause in plain English, and avoid abbreviations.

V S 150

66230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 13 1a

Registered No. 66230

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hereford Blvd.
(c) Hospital or institution: Catholic Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2719 Hampden (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Celia Bell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced divorced

6 (b) Name of husband or wife Charles Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 30 1875

8. AGE: Years 72 | Months 10 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Brockman Valley Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Brockman
13. Birthplace Md

MOTHER
14. Maiden Name Susan Ann Myers
15. Birthplace Md

16 (a) Informant Mrs Mary Smith Daughter
(b) Address 2719 Hampden

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Johnathan Miller
Location Carroll Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (Date rec'd by registrar) AUG 28 1948 (b) Huntington Williams M. D.

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948, at 2 30 am M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1948 to Aug 27 1948, and that I last saw her alive on Aug 26 1948

Immediate cause of death	Duration
Bronchial Asthma 3	14yr
Mitral Regurgitation 2	14yr
Due to Coronary Thrombosis (1)	4yrs
Due to Chronic Interstitial Nephritis	14yr
Other Conditions Interstitial nephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Stevens M. D.
Address 2878 Hereford Date signed 8-27-48

correct age is especially important. Physicians: please write the causes of death in plain English.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G66231

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2104 Longwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 Longwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Foster

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Geis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1878

8. AGE: Years 70 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, or state)

10. Usual Occupation Painter

11. Industry or business Self employed

FATHER
12. Name Edward Foster
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Cynthia Hill
15. Birthplace Md.

16 (a) Informant Mrs. Chas. E. Foster
(b) Address 2104 Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director L. Howard Strong
(b) Address 3207 W. North Ave.

19 AUG 28 1948 Registrar Burlington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27, 1948, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 20, 1948, to Aug. 27, 1948, and that I last saw him alive on Aug. 26, 1948

	Duration
Immediate cause of death: Circulatory failure	one week
Due to: Carcinoma of liver	6 mo.+
Due to: Carcinoma of thyroid gland	6 mo.+
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Apr. 27, 1948 + Hernia
Major findings of operation: Exploratory + resection of cancer of thyroid gland
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice E. Shamer M. D.

Address 3300 W. North Ave. Date signed 8/27/48

correct age is especially important. Physicians: please give the cause of death clearly.

V-S 150

G66232 8-20-48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G66232

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution:
Provident Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 427 N Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephanie Diana Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	negro	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/25/48

8. AGE: Years	Months	Days	If less than one day
		1	18 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Charles Scott
13. Birthplace Triangle Va

MOTHER
14. Maiden Name Lucile Thomas
15. Birthplace Baltimore

16 (a) Informant Lucile Thomas
(b) Address 427 N Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 28 48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore

18 (a) Funeral director Chas G. Cooper
(b) Address 513 N Carrollton Ave

Filed [illegible] for Withdrawal [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1948 to 8/27 1948.
and that I last saw h alive on 8/27 1948.

Duration

Immediate cause of death Pneumonia ?

Due to

Due to

Other Conditions Born of Caucasian mother
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred N. Constein M. D.
Address Provident Hosp Date signed

8-20-48

Please write plainly. Physicians: please write the cause of death clearly and legibly. Information is especially important. Physicians: please write the cause of death clearly and legibly.

666233 Butler 97

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 14 - Division
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 14
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 Division
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-25-94

8. AGE: Years	Months	Days	If less than one day
54	2	-	hr. — min.

9. Birthplace Gloucester Co. Va
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Gregory Scott
13. Birthplace Va

MOTHER
14. Maiden Name Sarah Morgue
15. Birthplace Va

16 (a) Informant Harry Butler
(b) Address 1604 Division St

17 (a) Burial (b) Date thereof 8/28/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Wm A Jackson
(b) Address 916 Pennsylvania Ave

19 AUG 28 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25/48, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20-1948 to 8-25-1948, and that I last saw h[illegible] alive on 8-25 1948.

Immediate cause of death Hypostatic pneumonia

Due to Pulmonary congestion + edema

Due to

Other Conditions Cirrhosis of liver generalized
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Resident
Address Date signed 8-27-48

VS 130

111c

correct age is especially important. Physicians: please write the cause of death plainly

66234

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

Registered No. 66234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 94 days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707-W. Mosher
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mrs. Mary A. Dorsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1876

8. AGE: Years 72 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Daniel Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Emmeline Thomas
15. Birthplace Md.

16 (a) Informant Mrs. Charles Dorsey
(b) Address 707 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore, Md.

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Pennsylvania Ave.

19 AUG 28 1948 (Date rec'd by registrar) Registrar Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 1948 at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21- 1948 to 8-26- 1948, and that I last saw h[illegible] alive on 8-26- 1948.

Immediate cause of death Pulmonary edema — Duration

Due to Cardiovascular renal heart disease

Due to

Other Conditions Ligation neck of femur

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5-21-48 at ? M
(c) Where did injury occur? 707 W. Mosher St. Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None (Specify type of place) While at work? no
(e) Means of injury Fell down stairs

23. Signature Howard J. Moffett, M.D.
Address Lombard & Gay Date signed 8/27/48

VS 190

correct age is especially important. Physicians: please write the cause of death clearly

66235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G66235

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hosp. 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Arlington Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lyeneer Parker

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-14-[illegible]34

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	N	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1904

8. AGE: Years	Months	Days	If less than one day
43	11	19	hr. min.

9. Birthplace Williamsburg, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Parker
13. Birthplace Williamsburg, Va

MOTHER
14. Maiden Name Elizabeth Cook
15. Birthplace Williamsburg, Va

16 (a) Informant Frank C. Roberts
(b) Address 1011 N. 42nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Wm. George A. Holland
(b) Address 1631 Druid Hill Ave.

19 AUG 23 1948 (Date received by registrar) (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27-48 19 . at 7 15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 1948 to 8-27 1948, and that I last saw h. 1M alive on 8-24 1948.

Immediate cause of death (a) Malignant Hypertension — Duration 6 mos-1yr.
(b) Cardiac Hypertrophy
(c) Chronic Passive Cong.-Liv.
Due to (d) Pulmonary edema Cong.-C adhesive pleuritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Simon H. Carter, J.F.
Address Provident Hosp. Date signed 8/28/48

VS 190

correct age is especially important. Physicians: please write the causes of death clearly and legibly

66236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

Registered No. G66236

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 N. Appleton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 N. Appleton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY LOTTIE EMORY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Zebbie D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1882

8. AGE: Years	Months	Days	If less than one day
65	10	16	hr. min.

9. Birthplace Baltimore, Maryland,
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Dorsey
13. Birthplace Maryland.

MOTHER
14. Maiden Name Emma Stewart
15. Birthplace Maryland.

16 (a) Informant Zebbie D. Emory
(b) Address 1713 N. Appleton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) AUG 27 1948 Huntington Williamsport
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1948, at 2 55 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1948 to Aug 25 1948, and that I last saw her alive on Aug 25 1948

Immediate cause of death Uremia — Duration 2 days

Due to Chr. Glomerular Nephritis — Duration undet.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Harland Rinnell M. D.
Address 902 W. Franklin Date signed 8-27-48

VS 153

G666237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47D

Registered No. G666237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Springfield Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henderson Wike

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/85

8. AGE: Years 63 | Months 5 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Self

FATHER
12. Name Harry Wike
13. Birthplace Penna.

MOTHER
14. Maiden Name Jurietta Weaver
15. Birthplace Penna.

16 (a) Informant Mrs Florence D. Wike
(b) Address 713 Springfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory Cedar Grove
Location Petersburg Penna

18 (a) Funeral director John A Moran
(b) Address 3026 E. Balt. St.

19 (a) AUG 28 1948 (Date rec'd by registrar) Huntington Williams, M.D. Address 1211 Eutaw Pl. Date signed 8/27/48

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1948 at 1:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 24, 1948 to August 27 1948. and that I last saw him alive on Aug. 27, 1948.

Immediate cause of death Carcinoma of lung with metastasis to mediastinum and liver — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Ca of lung with metastasis to liver

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ray E. Pyson Jr. M. D.
Address 1211 Eutaw Pl. Date signed 8/27/48

VS 150

66238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66238

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp, Balto, md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside corporate limits, write RURAL, and name town)
(d) Street No. 4103 Old Frederick Rd. Blessed Sacrament (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Reverend James A. O'Connell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 19, 1873

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75	7	6		

9. Birthplace Canada (Town, county, and state)

10. Usual Occupation Priest

11. Industry or business

FATHER
12. Name Charles O'Connell
13. Birthplace Canada

MOTHER
14. Maiden Name Mrs. Ellen O'Connell
15. Birthplace Canada

16 (a) Informant Father Healy HEALY
(b) Address Blessed Sac. Church, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3006 E. Baltimore St.

19 (a) AUG 28 1948 (Date rec'd by registrar) (b) Thurlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25-48 19 , at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 19 48 to 8-25 19 48 and that I last saw h[illegible] alive on 8-25 19 48.

Immediate cause of death Pneumonia — Duration 5 days

Due to

Due to

Other Conditions Generalized Arteriosclerosis — Benign Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rev. Powell, Jr. M. D.
Address Mercy Hosp Date signed 8-25-48

VS 150

Approved by Medical Examiners office

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. 6662239

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: D.O.A. BALTIMORE CITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2633 Mure Str. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Marie Hess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years | Months 2Mos. | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Hess

13. Birthplace Maryland

MOTHER 14. Maiden Name Ida Edelmann

15. Birthplace Maryland

16 (a) Informant James Hess

(b) Address 2633 Mura St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd

18 (a) Funeral director John A. Moran

(b) Address 3000 E. Balt St.

19 (a) Filed 8-28-48 (b) Remington Baltimore Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 1948, at 6:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death Congenital Heart disease

Due to

Due to

Other Conditions Mongolism Clint

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 8/27/48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. E. H. Rombold M. D.

Address Baltimore City Hospitals Date signed 8/27/48

VS 152 John R. Davis, M.D. per:

666240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 666240

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27-5
(c) Hospital or institution: SOUTH BALTIMORE GENERAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County .....
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 CHRISTOPHER AVE. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Coe, Oscar L.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-10-7607

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife CARRIE COE
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MAY 11, 1880

8. AGE: Years 68 | Months 3 | Days 16 | If less than one day hr. ..... min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation UTILITY MAN

11. Industry or business WESTERN MD. DAIRY

FATHER
12. Name Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant CARRIE COE
(b) Address 3004 CHRISTOPHER AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory GREEN MOUNT CEM.
Location E. NORTH AVE.

18 (a) Funeral director Earl A. Kilmain
(b) Address 6867 HARFORD AVE

19 (a) AUG 28 1948 (Date rec'd by registrar) (b) Filed Aug 30 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27-1948 at 1.08 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26-1948 to 8-27-1948, and that I last saw him alive on 8-27-1948.

Immediate cause of death	Duration
Coronary artery disease with infarction	
Due to	
Due to	
Other Conditions Hypertensive cardiovascular disease	
Cardiac decompensation (Include pregnancy within 3 months of death)	

Date of operation .....
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury .....

23. Signature William A. Harvey M. D.
Address South Baltimore Gen Hosp Date signed 8-27-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G66241

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address — 15
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 Elgin ave. Baltimore 16, Md. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE REBECCA BONN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 20, 1868

8. AGE: Years 79 | Months 9 | Days 7 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None (Used to be school teacher)

11. Industry or business —

FATHER
12. Name ANTHONY S. BONN
13. Birthplace Maryland (Baltimore)

MOTHER
14. Maiden Name MARTHA [redacted] EWIN
15. Birthplace West Virginia

16 (a) Informant MRS. WILLIAM EWIN BONN
(b) Address 506 Amalie Rd., Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 28 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1948, at 7:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23, 1948, to Aug. 27, 1948, and that I last saw h[illegible] alive on Aug. 27, 1948.

Immediate cause of death Circulatory collapse — Duration, 4 days

Due to Myocardial infarction — 3 yrs.

Due to Hypertensive arteriosclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None obtained

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. P. Benson, Jr. M. D.
Address 101 E. 33d St. Date signed 8-27-48

G66242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G66242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 462 E. Federal St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 462 E. Federal st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME Rachel A. Bond

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	colored	Widowed

6 (b) Name of husband or wife Jno. W. Bond (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1882

8. AGE: Years	Months	Days	If less than one day
66	6	8	hr. min.

9. Birthplace Harford co. Md (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Samuel Johnson
FATHER 13. Birthplace Harford Co. Md.

MOTHER 14. Maiden Name Eliza Giles
MOTHER 15. Birthplace Harford co. Md.

16 (a) Informant Mrs Merietta Stewart
(b) Address 3110 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/48 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson, Md.

18 (a) Funeral director William Chapman
(b) Address 1701 McCulloh St.

19 AUG 28 1948 (Date received by registrar) [illegible] (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 1948 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1948 to 8/26 1948 and that I last saw h[illegible] alive on 8/25 1948

Immediate cause of death: cerebral hemorrhage — Duration: 7 days

Due to hypertensive cardio-vascular-renal disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address RAYNER BROWNE, M.D. Date signed 8/27/48
1500 EAST MADISON ST.
BALTIMORE 5, MD.

VS 130

correct age is especially important. Physicians: please write the causes of death plainly.

G66243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 110 B

Registered No. G66243

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 Spring Court
(c) Hospital or institution: 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Zoyrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Spring Court (If rural, give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Sylvia Frazier

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thomas

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug 1, 1881

8. AGE: Years 68 | Months - | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Augusta Ga. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Henry Gibson
13. Birthplace Ga.

MOTHER 14. Maiden Name Katie ?
15. Birthplace Ga.

16 (a) Informant Katie Ollie Frazier
(b) Address 207 N. Spring St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus Md.

18 (a) Funeral director Mo. Roth & Elliott or Dff
(b) Address 1121 N. Carlin St

19 (a) Aug 28 1948 (b) Lexington-Wilkens, Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24-1948, at 7:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1948 to 8-24 1948 and that I last saw him alive on 8-24 1948

Immediate cause of death: (a) Bronchio Pneumonia & Pleurisy — Duration 10 days 7 days

Due to Exposure

Due to Cold

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) while at work?
(e) Means of injury

23. Signature Geo. R. Blake M. D.
Address 1603 N. Carlin Date signed 8/27

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66244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

Registered No. G66244

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Maryland General Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Linden Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Barbara Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife ROBERT

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 21, 1921

8. AGE: Years 27 | Months 0 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace MICHIGAN
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name CHARLES CHARTIER
13. Birthplace MICHIGAN

MOTHER
14. Maiden Name LOIS
15. Birthplace MICHIGAN

16 (a) Informant ROBERT MARTIN
(b) Address 1510 LINDEN AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 30 '48 (month) (day) (year)
(c) Cemetery or crematory MT OLIVET
Location FREDERICK AVE

18 (a) Funeral director Nam H Wyche
(b) Address 4141 Edmondson Ave

19 AUG 28 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26-48 19.., at 1 12 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull - Intracranial Hemorrhage

Due to .....

Other Conditions Mental Depression

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-26-48 at 12 20 P M.
(b) Where did injury occur? 1510 Linden Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Outside 1510 Linden Ave While at work? No
(d) Means of injury Jumped Out Window

23. Signature Robert B. McFadden M.D.
Medical Examiner.
Date signed 8-27-48

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66245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 115C

G66245 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1937 W Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MASTER WAYNE LEE BRUCE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25, 1937

8. AGE: Years	Months	Days	If less than one day: hr.	min.
10	11	2		

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Gifford Bruce

13. Birthplace Md.

MOTHER 14. Maiden Name Frieda Sadofsky

15. Birthplace Md

16 (a) Informant Mr. Gifford Bruce

(b) Address 1937 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30/48 (month) (day) (year)

(c) Cemetery or crematory Meadowridge

Location Bonny M.D.

18 (a) Funeral director Henry A. Wilhelm

(b) Address 410 Edmondson Ave

19 (a) AUG 28 1948 (Date rec'd by registrar) (b) Signature for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948, at 2 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1948, to 8/27 1948, and that I last saw h i.m. alive on 8/27 1948.

Immediate cause of death Hemorrhage (shock) — Duration

Due to Post. operative tonsillectomy

Due to

Other Conditions Pos - Rheumatic fever (Include pregnancy within 3 months of death)

Date of operation 8/26/48

Major findings of operations Hypertrophied tonsillitis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph R. Liberto M. D.

Address Bon Secours Hosp Date signed 8/27/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G666246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. CAREY ST
(c) Hospital or institution: Good Samaritan Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 HOLLINS ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARION L STEWART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 23, 1898

8. AGE: Years 50 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name CHARLES STEWART

13. Birthplace MD

MOTHER 14. Maiden Name SARAH NEWLIN

15. Birthplace MD

16 (a) Informant MR THEODORE STEWART

(b) Address 1302 HOLLINS ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG 30 '48 (month) (day) (year)

(c) Cemetery or crematory LORRAINE PK

Location 3801 FREDERICK AVE

18 (a) Funeral director Henry N Wilhelm

(b) Address 4101 [illegible]

19 AUG 28 1948 (Date received by local registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 26 1948 at 4:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1948, to Aug 26 1948 and that I last saw him alive on Aug 26 1948

Immediate cause of death: Generalized Carcinomatosis — Duration 3 mos.

Due to Carcinoma Rt. Breast — unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Cumunello M. D.

Address 910 W. Lombard St Date signed Aug. 24-

1948.

correct age is especially important. Punctuate.

VS 181

X

66247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

✓ G66247 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Provident Hospital 17-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(c) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Argyle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD ADAMS

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-03-6544

4. Sex: male
5. Color or race: colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) -·-·1893
8. AGE: Years 55 Months Days If less than one day hr. min.
9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name ?
13. Birthplace S. C.

MOTHER
14. Maiden Name ?
15. Birthplace S. C.

16 (a) Informant Sarah Nickens
(b) Address 1105 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Ac. Halstead

18 (a) Funeral director Reid Hall
(b) Address 914 Pennington Ave Baltimore Md

19 (a) AUG 28 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1948, at 3.20a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner
Date signed August 23, 1948

VS 181

66248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G66248

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 23-1 DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Peach Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENSE CHASE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: unknown

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2/1882

8. AGE: Years 67 | Months 8 | Days 22 | If less than one day hr. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name ? Philip Chase

13. Birthplace Calvert Co. Md.

MOTHER 14. Maiden Name Annie ?

15. Birthplace Calvert Co. Md.

16 (a) Informant Ethel Brown

(b) Address 1015 Peach Street

17 (a) (Burial, cremation, or removal) (b) Date thereof 8 29 48 (month) (day)

(c) Cemetery or crematory Mt. Calvary Cemetery

Location Baltimore

18 (a) Funeral director Walter B. Sapp

(b) Address 139 W. Hamburg St.

19 (a) AUG 28 1948 (Date received by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948, at 1:55 P M

21. I certify that I took charge of the remains described above, held an inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 8/25/48

G66249 BC-48-18583

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

V G66249 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs 45"
(e) Length of stay in Baltimore (yrs., mos., or days) 2hr 45"

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
9 City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 Stone Wood Rd. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl VON PARIS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife NONE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 25/48

8. AGE: Years | Months | Days | If less than one day: 2 hr. 45 min.

9. Birthplace BALTIMORE, Md. (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER 12. Name BONAVENTURE VON PARIS
13. Birthplace BALTIMORE

MOTHER 14. Maiden Name BERNICE CHEESUM
15 Birthplace Pa.

16 (a) Informant Bonaventure Von Paris
(b) Address 1522 Stonewood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Location Herman Mill Rd.

18 (a) Funeral director Charles S. Zeiler
(b) Address 901 S. Conkling St.

19 AUG 28 1948 (Date received by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 25 1948 at 8 PM

21. I certify that death occurred on the date above stated; that I attended deceased from AUG 25 1948 to AUG 25 1948, and that I last saw h CA alive on AUG 25 1948.

Immediate cause of death: Cardio Resp failure — Duration: 2 hrs.
Due to: Prematurity
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Joseph L. Aponte M.D.
Address Mercy Hosp Date signed 8/

X

VS 150

66250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G66250

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4r
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) H.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Hampstead
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Eburg

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Estella F Eburg

6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Mar 27-1869

8. AGE: Years	Months	Days	If less than one day: hr.	min.
79	5	1		

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Henry Eburg
13. Birthplace Md

MOTHER
14. Maiden Name Mary Sinkel
15. Birthplace Md

16 (a) Informant Maurice Eburg
(b) Address Hampstead Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 30/48 (month) (day) (year)

(c) Cemetery or crematory Hampstead
Location Carroll Co Md

18 (a) Funeral director Edw C Tipton
(b) Address Hampstead Md

19 (a) Filed AUG 29 [redacted]
(b) (Date received by registrar) Registrar for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1948, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Aug 28 1948
and that I last saw h alive on Aug. 27 1948

Immediate cause of death	Duration
Aspiration of faeces	
Due to generalized debility	
Due to Cardiac & renal failure	
Other conditions Incomplete fr. intertrochanteric left femur	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8-20-48 at , M
(c) Where did injury occur? Hampstead, Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fall out of bed

23. Signature R. C. Hunter, M.D.
Address University Hospital Date signed 8-28-48

Homer J. Knudsen, M.D. 168

VS 150

666251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125a

Registered No. 666251

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Edmonston
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Ann Franklin

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-26-3402

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 8, 1930

8. AGE: Years	Months	Days	If less than one day
17	11	19	hr. min.

9. Birthplace Phila., PA.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name JAMES M. FRANKLIN
13. Birthplace CHURCHTON, MD

MOTHER
14. Maiden Name FANNIE CROUCH
15. Birthplace CHASE, MD.

16 (a) Informant JAMES M. FRANKLIN
(b) Address CHURCHTON, MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Aug. 30 1948 (month) (day) (year)
(c) Cemetery or crematory ST. JAMES
Location TRACEY'S, MD.

18 (a) Funeral director J. A. Hardesty & Son
(b) Address Galesville, Md.

AUG 29 1948 (Date filed by registrar) Allington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948, at 4 50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1948 to 8/27 1948, and that I last saw her alive on 8/27 1948.

Immediate cause of death: Acute Yellow Atrophy — Duration

Due to Cirrhosis & Ileus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Hepatomegaly + splenomegaly

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Benson M.D.
M. D.

Address Un. Hospital Date signed 8/27/48

VS 150

G66252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registrar's No. G66252

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Del~~ Md (b) County Cecil
Excepted Middletown
(c) City or town Middletown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bennett Broaddus

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Stella
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 12-25-90

8. AGE: Years 57 | Months 8 | Days 2 | If less than one day: hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Andrew Broaddus
13. Birthplace Va.

MOTHER
14. Maiden name Sallie Washington
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Cecilton
Location Cecilton Md
(a) Funeral director Edward Fellows
(b) Address Middletown, Md

8-29-1948 (Date received) (Registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3 1948 to 8/27 1948 and that I last saw h alive on 8/27/1948.

Immediate cause of death: Mediastinitis and secondary Empyema pulmonalis
Due to: Removal of cancer of Esophagus
Due to: Stomach and Esophagus
Other Conditions: Anemia
(Include pregnancy within 3 months of death)

Duration: 1 mo / 5 mo

Date of operation 8
Major findings of operation: Ca. of Stomach & Esophagus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thomas A. Gott
Address JOHNS HOPKINS HOSPITAL Date signed 8/27/48

VS 150

666253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. 666253

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 N Collington ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 405 N Collington ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moses Brafman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Amelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 18 1869

8. AGE: Years	Months	Days	If less than one day
79	7	9	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Solomon Brafman
13. Birthplace Germany

MOTHER
14. Maiden Name
15 Birthplace Germany

16 (a) Informant Sol Brafman
(b) Address 2047 Ruxton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory Shel Yakov Cong
Location Herring Run

18 (a) Funeral director Sol Levinson Bros
(b) Address 1124-26 W. North Ave.

(a) Aug 29 1948 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1948 to Aug 24 1948 and that I last saw h[illegible] alive on Aug 24 1948

Immediate cause of death	Duration
Cardiac failure	2 mos
Due to Cardio Vascular	2
Due to Uremia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Sullivan M. D.
Address 100 W Mulberry Date signed 8/28/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

066254 ✓ 066254 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Esplanade Apt. 7BB
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Esplande apts 7 B B (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DR. Lewis Emanuel Hess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male.	white	Widower

6 (b) Name of husband or wife Marie Salaves
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1871

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76	11	17		

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Emanuel Hess
13. Birthplace Germany

MOTHER
14. Maiden Name Rebecca Rosenstock
15. Birthplace Baltimore, Md.

16 (a) Informant Lewis Hess
(b) Address 618 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Belair Road

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North Ave
Baltimore, Md.

AUG 29 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1948, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1948 to Aug 28 1948, and that I last saw him alive on Aug 27 1948.

Immediate cause of death Coronary Occlusion — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Donald Jandorf M. D.
Address 4077 Hanford Rd Date signed 8-28-48

VS 150

R. Donald Jandorf

666255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 666255

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2616 Park Heights Terrace
(c) Hospital or institution:

1613

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2616 Park Heights Ave. Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mollie Rubinstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1880

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Joseph Rubinstein
(b) Address 2616 Park Heights Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-48 (month) (day) (year)
(c) Cemetery or crematory Arlington Cemetery
Location Rodgers Ave

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1124-26 W. North Avenue

AUG 29 1948 (Date rec'd by registrar) Registrar for Wards

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 19 48, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 1948 to Aug. 28 1948, and that I last saw h[illegible] alive on Aug 27 1948.

Immediate cause of death cardiac failure — Duration

Due to Arteriosclerotic heart disease — 10 yrs.

Due to Coronary sclerosis

Other Conditions Urinary tract infection, Chronic bronchitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Burgin M. D.
Address 6721 Reisterstown Rd Date signed Aug. 28 1948

VS 199

X

G66256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G66256
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2902 Norfolk Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 17
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2902 Norfolk Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Fink

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age 187 years

7. Birth date of deceased (mo., day, yr.) Aug. 25, (1871)

8. AGE: Years 77 | Months - | Days 2 | If less than one day / hr. min.

9. birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Joseph Fink
13. Birthplace Poland

MOTHER
14. Maiden Name Jennie ?
15 Birthplace Poland

16 (a) Informant Bessie Fink
(b) Address 2902 Norfolk Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8- 29- 48 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cong.
Location Southern Avenue

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1124-26 W. North Ave.

AUG 29 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27, 1948, at 12:1 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Aug 1948.
and that I last saw h alive on Aug 27 1948.

Immediate cause of death Heart Failure — Duration ?

Due to Arteriosclerosis — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Lisansky M. D.
Address 320 Liberty Hgts Date signed

VS 193

G66257

BALTIMORE CITY HEALTH DEPARTMENT ✓ G66257
Registered No.

CERTIFICATE OF DEATH 74a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai 137
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Rosenbaum

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Heinrich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 885

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Germany (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

12. Name of father Isaac
13. Birthplace Germany
14. Maiden Name of mother Flora
15. Birthplace Germany

16 (a) Informant George Salomon
(b) Address 2360 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Belair Road

18 (a) Funeral director Lee Lewis & Son
(b) Address 2416 Eutaw Place

(c) Registrar [illegible] Washington Blvd

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1948, at 10:47 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1948, to Aug 28 1948, and that I last saw her alive on Aug 27 1948.

Immediate cause of death Acute Leukemia
Bronchopneumonia

Duration

Due to

Due to

Other Conditions Atelectasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Koch
Address Sinai Hosp. Date signed 8/27/48 M. D.

Correct age is especially important. Typewrite or print plainly with indelible pencil.

VS 150

666258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 69

666258 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 76 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Light St
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Lee Mayer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/3/71

8. AGE: Years 76 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation druggist

11. Industry or business

FATHER 12. Name Lee

13. Birthplace Germany

MOTHER 14. Maiden Name Rosa Reef

15. Birthplace Germany

16 (a) Informant Wm J Schmitt

(b) Address 1644 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-48 (month) (day) (year)

(c) Cemetery or crematory Beth Sholom

Location Donnell St

18 (a) Funeral director Jack Lewis Inc

(b) Address 2106 Eutaw Place

AUG 29 1948

(Registered by registrar) (Date) Covington Williams Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 1948, at 6 AM M

21. I certify that death occurred on the date above stated, that I attended deceased from 7/31 1948 to 8/26 1948, and that I last saw h[illegible] alive on 8/26 1948.

Immediate cause of death Cerebral hemorrhage — Duration

Due to Cerebral thrombosis / Heart Disease

Due to

Other conditions Pellagra / Carbon Monoxide
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Blank M. D.
Address Maryland General Date signed

931

BALTIMORE CITY HEALTH DEPARTMENT ✓ 666259 Registered No.

CERTIFICATE OF DEATH 61

666259

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3438 Piedmont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3438 Piedmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Fiskind
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Bessie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1873
8. AGE: Years 75 | Months | Days | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER 12. Name Not Known
13. Birthplace Russia
MOTHER 14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Bessie Fiskind
(b) Address 3438 Piedmont Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-48 (month) (day) (year)
(c) Cemetery or crematory Loudale
Location Old Rd. & Hamilton Ave
18 (a) Funeral director Jack Lewy one
(b) Address 2402 Eutaw Place
19 (a) 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-1948, at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1934 to Aug 28 1948
and that I last saw him alive on Aug 27 1948

Immediate cause of death	Duration
Coronary thrombosis	3 days
Due to Coronary artery disease	6 years
Due to Arterio-sclerosis & diabetes	10 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack Cohen M. D.
Address 1804 Eutaw Place Date signed 8/28/48

VS 150

666260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666260

1579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument St
(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 Adler Drive Alden
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lurie

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/25/48

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

12. Name William Lurie
13. Birthplace New York
14. Maiden Name Shirley Illions
15. Birthplace New York

16 (a) Informant William Lurie
(b) Address 10 Adler Drive

17 (a) Sinai (b) Date thereof 8-29-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Friendship

18 (a) Funeral director Jack Lewis Inc
(b) Address 7106 Eastern Ave

AUG 30 1948
(Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1948 to Aug 27 1948 and that I last saw him alive on Aug 27 1948

Immediate cause of death: aspiration Pneumonia

Duration

Due to Blood from Upper Respiratory Tract

Due to Unknown reason

Other Conditions Mongolism Atresia 2nd part of Duodenum
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pneumonia Aspiration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sydney A Weston M. D.
Address Sinai Hospital Date signed Aug 29/48

VS 150

666261

AB-10150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1937

Registered No. 666261

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Normal Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Koenig

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8th 1881

8. AGE: Years	Months	Days	If less than one day
67	7	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Koenig
13. Birthplace Hungary

MOTHER
14. Maiden Name Frances Fisher
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto City Md.

18 (a) Funeral director Tasaduri Funeral Home
(b) Address 7401 Belair Rd

AUG 29 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27- 1948, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25- 1935 to 8-27- 1948, and that I last saw him alive on 8-27- 1948.

Immediate cause of death Pulmonary edema.
Due to Arteriosclerotic Cardio-vascular Disease
Due to
Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Asked.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Kuhen, M.D.
Address Balto City Hosp. Date signed 28 Aug 48.

VS 110

X

BC-66-1829 666262

BALTIMORE CITY HEALTH DEPARTMENT ✓ 666262
Registered No.

CERTIFICATE OF DEATH 1579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Jessups (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Vincent
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-25-48

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

MOTHER | FATHER
12. Name Richard
13. Birthplace Md.
14. Maiden Name Catherine Albers
15. Birthplace Md.

16 (a) Informant Richard Vincent
(b) Address Jessups, Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Evergreen Meth.
Location Balto. Co. Md.
18 (a) Funeral director Sassaman Funeral Home
(b) Address 7401 Belair Rd.
19 (a) (Date rec'd by registrar) (b) Filed by Wm. [illegible] Registrar

AUG 29 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1948 9:30 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 8-25 1948 to 8-28 1948
and that I last saw h[illegible] alive on 8-28 1948
Immediate cause of death Acute Empema — Duration

Due to Diffuse peritonitis

Due to Congenital volvulus of terminal ileum (Meckel's diverticulum)

Other Conditions (Include pregnancy within 3 months of death)

Date of operation 8/28/48
Major findings of operation: Congenital volvulus terminal ileum
of autopsy: See as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter J. Bernard M. D.
Address St. Agn's Hosp. Date signed 8/28/48

G66263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66263 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or Institution St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 851 Wellington (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary E. Wilson
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex F.
5. Color or race W.
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife James Wilson
6 (c) If alive, give age
7. Birth date of deceased (mo., day, yr.) Aug. 1, 1867
8. AGE: Years 81 Months — Days 25 If less than one day hr. min.
9. Birthplace Baltimore Co. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business
FATHER 12. Name Thomas B. Cole
13. Birthplace Maryland
MOTHER 14. Maiden Name Rebecca Cole
15. Birthplace Maryland
16 (a) Informant Milton F. Cole
(b) Address 27 East 21st Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore Co., Maryland
18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
19 (a) Aug 30 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 1948, at 3:15PM
21. I certify that death occurred on the date above stated; that I attended deceased from July 11, 1948 to Aug. 26, 1948, and that I last saw her alive on Aug. 26, 1948.

	Duration
Immediate cause of death Cerebral-Vascular Accident	
Due to Generalized Arteriosclerosis	
Due to Arterio-sclerotic Heart Disease	
Other Conditions Cardiac Insufficiency (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Ray E. Pingue Jr.
Address St. Joseph's Hosp. Date signed 8/29/48

VS 150

G66264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G66264
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2406 ARLINGTON AVE.
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7D
(e) Length of stay in Baltimore (yrs., mos., or days) 74 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE, MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 ARLINGTON AVE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA ELIZABETH VICKERS.

3 (b) If veteran, name war —
3 (c) Social Security Account No. NONE.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	MARRIED

6 (b) Name of husband or wife ROBERT E. VICKERS
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) FEB. 2 1874

8. AGE: Years	Months	Days	If less than one day
74	6	8	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE.
11. Industry or business —

FATHER
12. Name JOSEPH G. BISSER
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name LENA BENNETT
15. Birthplace BALTIMORE, MD.

16 (a) Informant HUSBAND (ROBT. E. VICKERS
(b) Address 2406 ARLINGTON AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Highway
18 (a) Funeral director Wm. H. Reynolds
(b) Address [illegible] Washington Nat'l Bank
(Deputy registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 28, 1948 at 3 50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 14 1948 to AUG 28 1948 and that I last saw HER alive on AUG. 28 1948.

Immediate cause of death	Duration
ACUTE CARDIAC DECOMPENSATION	2 WEEKS
Due to ARTERIOSCLEROTIC CVDis.	2 YRS.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation:
of autopsy NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur Karfgin M. D.
Address 4230 LOCH RAVEN BLVD. Date signed 8-28-48

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 1150

G66265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125B

G66265 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline
(c) Hospital or ~~Institution~~ St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Carroll
(c) City or town Rural Mt. Airy (If outside city or town limits, write RURAL and give town)
(d) Street No. Hill (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Scheller, Mrs. Effie

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	

6 (b) Name of husband or ~~wife~~ William
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr) Jan. 13, 1886

8. AGE: Years	Months	Days	If less than one day
62	7	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own home

FATHER
12. Name George Gartrell
13. Birthplace Md

MOTHER
14. Maiden Name Untamme
15 Birthplace

16 (a) Informant Tom C. Scheller
(b) Address Mt. Airy Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Prospect
Location Mt. Airy Fred. Co. Md

18 (a) Funeral director E. M. Waltz
(b) Address Winfield, Md

19 (a) [illegible] (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29, 1948 at 2:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18, 1948 to Aug. 29, 1948, and that I last saw her alive on Aug. 29, 1948

Immediate cause of death Liver failure — Duration 1 wk.
Due to Cirrhosis of the liver
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 8-24-48
Major findings of operation: Large liver
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature J. Joseph Krejci M.D.
Address 1400 N. Caroline St. Date signed 8-29-48

VS 150

666266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

666266 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Rest Nursing Home 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 931 Montpelier Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLORA S. DAVIS

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1865

8. AGE: Years 83 | Months 4 | Days 7 | If less than one day: hr. min.

9. Birthplace: Highland Co. Virginia
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Frank Floyd
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Mary Page
15. Birthplace: Virginia

16 (a) Informant: Mrs. Ruth Zinn
(b) Address: 931 Montpelier Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. (month) 1948 (year)
(c) Cemetery or crematory: Odd Fellows
Location: Salem, W. Va.

18 (a) Funeral director: William Cook, Inc.
(b) Address: 1217 St. Paul Street

AUG 29 1948
(Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1948, to Aug 28 1948, and that I last saw her alive on Aug 27 1948

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	10 yrs
Due to Congestive Failure	1 week
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Wallenstein M.D.
Address 898 W 36th St Date signed 8/28/48

G66267

223701

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52a

G66267
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 S. Broadway, (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Parkes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-27-77

8. AGE: Years	Months	Days	If less than one day hr.	min.
71	0	1		

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Turner
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Burnett
15. Birthplace Md.

16 (a) Informant Della Johnson-935 S. Broadway
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)
(c) Cemetery or crematory Abingdon M.E. Church
Location Harford Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 427 St. Paul St.

19 AUG 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-28- 1948 at 3: A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-[illegible]-48 1948. to 8-27- 1948.
and that I last saw her alive on 8-27- 1948.

Immediate cause of death	Duration
[illegible]	
Carcinoma of Kidney Pelvis, Left.	10 months
Due to Metastasis to liver.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Feb. 1948
Major findings of operation: Nephrectomy
of autopsy: Carcinoma of K. Pelvis
not permitted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Mason C. Andrews M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 8-27-48

VS 150

G66268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G66268
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 Wilkins Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward T. MERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
M	W	Widowed

6 (b) Name of ~~husband or~~ wife Margaret Merson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14th 1884

8. AGE: Years	Months	Days	If less than one day
64	0	12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Building

FATHER
12. Name Thomas Merson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Oswald Merson
(b) Address Ft. Pleasant, A.A.Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month, day, year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location Balto. Md.

18 (a) Funeral director Wilkins Cook Inc.
(b) Address 1217 St. Paul St

AUG 29 1948
(Date rec'd by registrar) (b) Huntington Hollins, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948 at 5:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident prob. ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Contusion of spinal cord.
Edema of lungs.
~~Due to~~ Arteriosclerotic cardiovascular disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury July 25 at 20:3 M.
(b) Where did injury occur? Above address
(d) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Fall down steps (inside)

23. Signature George H. Merrill M.D.
Medical Examiner.
Date signed 8/27/48

G66269

BALTIMORE CITY HEALTH DEPARTMENT ✓ G66269 Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 Nottingham Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Nottingham Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter A Tassos

3 (b) If veteran, name war: No | 3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28 1884

8. AGE: Years 58 | Months 7 | Days 28 | If less than one day: hr. min.

9. Birthplace Turkey (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Athanasios Tassos
13. Birthplace Turkey

MOTHER 14. Maiden Name Lingakis
15. Birthplace In Turkey

16 (a) Informant Mrs Marie M Tassos
(b) Address 604 Nottingham Rd

17 (a) Burial Fune (Burial, cremation, or removal) (b) Date thereof 8 30 48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Baltimore Co Md

18 (a) Funeral director Nelson & Joe
(b) Address 1219 E Fayette St

19 (a) 8 30 1948 (Date received by registrar) (b) Registrar Nicholas for Wilkinson, MD

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1948 at 6 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 1946 to 8/26 1948
and that I last saw h/m alive on 8/26 1948

Immediate cause of death	Duration
Cerebral hemorrhage	8/26/48
Due to Hypertensive cardio vascular Disease	ca 1945
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 3629 Edmondson Date signed 8/27/48 M. D.

correct age is especially important; if unknown, please write

G66270
M. - 122075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

Registered No. G66270

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5519 Summerfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Northling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Lawrence C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 29, 1887 ?

8. AGE: Years	Months	Days	If less than one day
61 ?	2	29	hr. min.

9. Birthplace ?
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 8/30/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto.
Location " Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St. Paul St.

AUG 29 1948
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1948 at 1.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1948 to Aug. 27 1948, and that I last saw h er alive on Aug. 27 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Brain Tumor, Cystectomy, Recurrent, Left frontal	
Due to	
Other Conditions Immune Pneumonia & Syphilis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address Date signed M. D.

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G66271

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

75c

Registered No. G66271

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution: Calvert & Saratoga Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 9 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore, 18.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Yolanda Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Gerard.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 15, 1943

8. AGE: Years	Months	Days	If less than one day
5	6	12	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Wilbert E. Gerard
13. Birthplace Maryland
14. Maiden Name Elizabeth Voith
15. Birthplace Baltimore

16 (a) Informant Wilbert E. Gerard.
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Old Frederick Road

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 1318 Light St.

19 AUG 29 1948 Registrar for Williamsport, Md.
(Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948 at 8:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 18, 1948 to Aug. 27 1948. and that I last saw him alive on Aug. 27, 1948.

Immediate cause of death: Cerebral hemorrhage — Duration 11 hrs.

Due to Aplastic Anemia

Due to

Other Conditions Generalized hemorrhages.
(Include pregnancy within 3 months of death)

Date of operation Splenectomy

Major findings of operation: July 31, 1948

of autopsy: Gen. hemorrhages - blood stained serum, stroma collapsed

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence /at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Enos M.D.
Address Mercy Hosp. Date signed 8/27/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

G66272

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 126

G66272 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkins ave.
(c) Hospital or institution St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 7 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 S. Augusta Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edith V. Rosenberger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife George W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 7, 1884

8. AGE: Years 64 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Elijah A. Dorsey
13. Birthplace Md

MOTHER 14. Maiden Name Sarah V. Grimes
15. Birthplace Md.

16 (a) Informant Mrs. Philip Benson
(b) Address 2145 S. Augusta ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave. & Fayette St.

19 (a) Date received by Registrar AUG 29 1948 (b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1948, at 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18/ 1948, to 8/27/ 1948, and that I last saw her alive on 8/21/ 1948.

Immediate cause of death Cardio respiratory failure. — Duration 2.

Due to Hypostatic pneumonia 1 month

Due to Cholecystolithotomy. 2 days.

Other Conditions Diabetes mellitus.
(Include pregnancy within 3 months of death)

Date of operation August 25, 1948.

Major findings of operation Bilious Chronic - stone in common duct - CHOLECYSTITIS

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. H. Sherwin M. D.
Address Mercy Hosp. Date signed 8-27-48
Baltimore 2, Md.

66623 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66623

111a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 Howard Ave #1 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME John Wilmer Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/18/08

8. AGE: Years | Months | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER 12. Name Wilmer Smith
13. Birthplace BALTIMORE

MOTHER 14. Maiden Name MARY Davis
15. Birthplace W. Virginia

16 (a) Informant
(b) Address

17 (a) Aug 30/48 (Buried, cremation, or removal) (b) Date thereof Aug 29/48 (month) (day) (year)
(c) Cemetery or crematory New Cath. Location Edmondson Ave

18 (a) Funeral director M. N. Armacost
(b) Address 4204 Ridgewood Rd

Aug 29 1948 (Date received by registrar) Tom Taylor Williams, Registrar.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948 at 8:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1948 to Aug 27 1948, and that I last saw him alive on Aug 27 1948.

Immediate cause of death Pulmonary Embolus — Duration

Due to Dehydration & Acidosis

Due to Vomiting

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Avante
Address Mercy Hosp Date signed 8/28

VS 150

G66274 Colored G66274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 55B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hosp 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 2d
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 Walbrook (If rural give location)
(e) Citizen of foreign country? (Yes or No) N
If yes, name country

3 (a) FULL NAME Mrs. Bonnie Doulan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-31-1874

8. AGE: Years	Months	Days	If less than one day
74	4	27	hr. min.

9. Birthplace Balto - Md (Town, county, and state)
10. Usual Occupation H W
11. Industry or business

FATHER
12. Name George Walter
13. Birthplace Md

MOTHER
14. Maiden Name Mary Jewell
15. Birthplace Md

16 (a) Informant Daughter
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem
Location Govans Town Bank Co.

18 (a) Funeral director Edward Poulson
(b) Address 2511 W. Baltimore St. Baltimore, Md.

19 (a) 29 1948 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27 1948 at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1948 to 8-27 1948 and that I last saw her alive on 8-27 1948

Immediate cause of death (a) Cerebral Hemorrhage — Duration: about

Due to (b) Senescence

Due to (c)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Root M. D.
Address Church Home Hosp Date signed 8-27-48

VS 150

X

G66275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G66275 Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SOUTH BALTO. GEN.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (24)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6614 O'DONNELL ST.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country NATURALIZED

3. (a) FULL NAME Mincsik, Sr. Joseph
3 (b) If veteran, name war —
3 (c) Social Security Account No. 218-26-3567

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	MARRIED

6 (b) Name of husband or wife MARTHA
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) OCT. 3, 1879

8. AGE: Years	Months	Days	If less than one day
68	10	24	hr. min.

9. Birthplace YIRENA - CZECHO - SLOVAKIA (Town, county, and state)
10. Usual Occupation CLERK
11. Industry or business FOOD STORE

FATHER
12. Name JOHN MINCSIK
13. Birthplace CZECHO - SLOVAKIA

MOTHER
14. Maiden Name SALUNIK (?)
15. Birthplace CZECHO SLOVAKIA

16 (a) Informant MARTHA MINCSIK (WIFE)
(b) Address 6614 O'DONNELL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory ST. ANDREWS RUSSIAN
Location OLD GERMANTOWN RD. BALTO. CO.

18 (a) Funeral director Wells Byrnes Bradley
(b) Address 1922 W. North Ave.

19 (a) — (Date rec'd by registrar) (b) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27-1948 at 3 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 21 Aug 1948 to 27 Aug 1948 and that I last saw him alive on 27 Aug 1948.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Arteriosclerotic Heart Dis
Bronchial asthma
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature William J. Hawn M. D.
Address South Baltimore Gen Hosp Date signed 8-27-48

VS 150

corrected as to name is especially important. Physicians: please write the cause of death clearly and legibly.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G66276 — CERTIFICATE OF DEATH — 131a — G66276

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 Rutland Ave. (.....Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred.....yrs.....mos.....ds. How long in U. S. If of foreign birth?.....yrs.....mos.....ds.

2. FULL NAME Beatrice Clary

(a) Residence: No. 909 Rutland Ave. St., ... Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of William Clary 1872

6. DATE OF BIRTH (month, day, year) Aug. 27, 1882

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
76	-	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Norfolk, Va.

FATHER

13. NAME William Hill

14. BIRTHPLACE (city or town) (State or country) Norfolk, Va.

MOTHER

15. MAIDEN NAME Evelina Wright

16. BIRTHPLACE (city or town) (State or country) Portsmouth, Va.

17. INFORMANT Preston Hill

(Address) 909 Rutland Ave.

18. BURIAL, CREMATION, OR REMOVAL Burial

Place [illegible], Va. Date Sept. 4 1948

19. UNDERTAKER Geo. W. Nelson & Co.

(Address) 1323 Pennsylvania Ave.

20. FILED ..... 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 8-29 1948

22. I HEREBY CERTIFY, That I attended deceased from July 15 1948 to Aug 29 1948

I last saw h.. alive on 8/29/48 19..... Death is said to have occurred on the date stated above, at 2 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Nephritis	1 year

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Calvin B. LeCompte M. D.

(Address) 1113 N Caroline St

G66277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G66277 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Walker
(c) Hospital or institution: St. Agnes 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9da
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B. C. A.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2530 N. Charles St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Jennie V. Eby

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife James H. Eby
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) July 27 1859

8. AGE: Years 89 | Months 1 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Samuel Short
13. Birthplace Pa.

MOTHER 14. Maiden Name Catherine Parr
15. Birthplace Pa.

16 (a) Informant Arthur Eby
(b) Address 2530 N. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Henry W. Jenkins Sons Co.
(b) Address McCulloh & Richard Sts

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1948, at 8:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1948 to 8/28 1948 and that I last saw he alive on 8/28 1948.

Immediate cause of death Cerebral hemorrhage and uremia — Duration

Due to ?

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Frank M. Dwyer M. D.
Address St Agnes Hosp Date signed 8/29/48
Balto md

VS 150

G66278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66278 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Street
(c) Hospital or institution: Twilight Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Davidsonville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM OWENS TUCKER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fannie N. Tucker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): September 4, 1880

8. AGE: Years 68 | Months 11 | Days 25 | If less than one day: hr. min.

9. Birthplace: Lathian, Maryland (Town, county, and state)
10. Usual Occupation: Farmer
11. Industry or business:

FATHER
12. Name: Benjamin L. Tucker
13. Birthplace: Birdsville Maryland

MOTHER
14. Maiden Name: Margaret Owens
15. Birthplace: Lathian, Maryland

16 (a) Informant: Mrs. Fannie N. Tucker
(b) Address: Davidsonville, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory All Hollows Cemetery
Location: Annapolis, Maryland

18 (a) Funeral director: John M. Taylor Annapolis, Md.
(b) Address: 147-149 Gloucester Street

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1948, at 3.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Aug 27 1948 and that I last saw h alive on Aug 27 48.

	Duration
Immediate cause of death: Cerebral Hemorrhage	1 day
Due to: Myocardial Degeneration	3 yrs
Due to: Arteriosclerosis	5 yrs
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Homer E. Todd M.D.
Address 2108 E. Fayette St Date signed 8/29/48

correct age is especially important. Physicians, please write the cause of death plainly.

YS 183

G66279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66279
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Anne Arundel
(c) City or town Jessup Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Champion Forest
(If rural route, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS JESSIE MALONE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1873.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75	3	15		

9. Birthplace TAMAROS, ILL. (Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

FATHER
12. Name CYRIL WILLOUGHBY.
13. Birthplace ALA.

MOTHER
14. Maiden Name HARRIET PATRICK
15. Birthplace TENN.

16 (a) Informant MARION R. MALONE.
(b) Address CHAMPION FOREST, JESSUP, MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1, 1948 (Month) (day) (year)
(c) Cemetery or crematory Edenhill Cem.
Location SUITLAND MD.

18 (a) Funeral director J ARTHUR WALTERS.
(b) Address 505 WASH BLVD, LAUREL, MD.

19 (a) Date received AUG 29 1948 (b) Registrar for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29-48 19 at 12:01 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9-48 19 to 8-29-48 19, and that I last saw her alive on 8-26-48 19

Immediate cause of death	Resp. Failure	Duration
Due to	Overwhelming Toxemia	
Due to	Rocky Mountain Spotted Fever	
Other Conditions	Bronchopneumonia Right lung	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John White M.D.
Address Jessup. Md. Date signed 8-29-48

666280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 666280

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Aboard SS ALCOA PENNANT
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N C (b) County
(c) City or town Ashboro (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Worsham

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Melissa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years: 41 | Months | Days | If less than one day: hr. min.

9. Birthplace: Stokes N C (Town, county, and state)

10. Usual Occupation: Farmer

11. Industry or business

FATHER
12. Name: John T Worsham
13. Birthplace: N. C.

MOTHER
14. Maiden Name: Minnie Fulbono
15. Birthplace: N C

16 (a) Informant: W C Craven
(b) Address: SS ALCOA PENNANT

17. Interment (Burial, cremation, or removal) (b) Date thereof: 8/29/48 (Month) (Day) (Year)
(c) Cemetery or crematory: Ashboro
Location: Ashboro N C

18 (a) Funeral director: Fulbright Funeral Home
(b) Address: 614 E Post St

19 (a) Filed: AUG 30 1948 (Date filed by Registrar) (b) Registrar: Kensington Williams, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify) (While at work?)
(d) Means of injury

23. Signature: Earl L Craven M.D.
Medical Examiner.
Date signed 29 Aug 48

G66281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ..... 24 [illegible]
(c) Hospital or institution South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Warren St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Clyde Duncan

3 (b) If veteran, name war W | 3 (c) Social Security Account No. .....

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret

(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 22 1902

8. AGE: Years 40 41 | Months 9 6 | Days ..... | If less than one day ..... hr. ..... min.

9. Birthplace Parkersburg W Va (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bell Telephone Co

FATHER 12. Name Charles Duncan

13. Birthplace Kentucky

MOTHER 14. Maiden Name Agnes Quisenberry

15. Birthplace Kentucky

16 (a) Informant Mrs Morgan Duncan

(b) Address 411 Warren St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/41 (month) (day) (year)

(c) Cemetery or crematory Parkersburg W Va

Location Parkersburg W Va

18 (a) Funeral director Wilson & Dye

(b) Address 1217 [illegible] Huntington for Williamson, W Va

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1948, at 11:25 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur? .....

(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....

(d) Means of injury .....

23. Signature C. P. Jubrink M.D. Medical Examiner

Date signed 8/29/48

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G66282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G66282

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 21
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Just came

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4238 Nicholas Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Doris Eckenrode

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband ~~Wife~~ Geo. J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
48	47		hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Chas. Creighton

13. Birthplace Md

MOTHER 14. Maiden Name Amelia Dietzel

15. Birthplace Md

16 (a) Informant Hosp

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1-48 (month) (day) (year)

(c) Cemetery or crematory Wesley Chapel

Location Rock Creek Park

18 (a) Funeral director Colgan & Lang

(b) Address Church & Huntington Aves

19 (a) AUG 30 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29 1948, at 11:10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17-1948, to 8-29-1948, and that I last saw her alive on 8-29-1948.

Immediate cause of death Cardiac Failure — **Duration**

Due to Hypostasis (HAEMIA)

Due to Possible Leucopenia & Carcinoma of Peritoneum (SPLENIC)

Other Conditions Plaque Pressure with metastases. (Include pregnancy within 3 months of death)

Date of operation 8-15-1948

Major findings of operation: Carcinoma of peritoneum Pleura

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature C. S. Thomas M. D.

Address Mercy Hosp. Date signed 8-24-48

VS 150

G666283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G666283 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2502 Lakeland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Lakeland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Maud Hinks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: John T. Hinks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May - 3 - 1878

8. AGE: Years 70 | Months 3 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name William B. T. Davis
13. Birthplace Frederick Md.

MOTHER
14. Maiden Name Jenny Painter
15. Birthplace Virginia.

16 (a) Informant George A. Davis
(b) Address 1345 W. Baltimore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 / 30 / 48 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson & Longwood Sts

18 (a) Funeral director John J. Bowman & Son
(b) Address 901-03 Hollins St

19 (a) AUG 30 1948 (Date received by registrar) Henrietta Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August - 28 1948 at 1 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8 - 15 - 1948 to 8 - 28 - 1948, and that I last saw h[illegible] alive on 8 - 28 - 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2-3 years

Due to Hypertension

Due to

Other Conditions Bedsore

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Walter H. Sonnenfeld M.D.
Address 2708 Hollins Ferry Rd Date signed 8/28/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G66284

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St + Linden Ave
(c) Hospital or institution: 24th
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 82 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 East Fort Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janie Armstrong Robbins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Edward E. Robbins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-15-65

8. AGE: Years	Months	Days	If less than one day
82	9	14	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Wm McCulley
13. Birthplace Md

MOTHER
14. Maiden Name Caroline Eckhardt
15. Birthplace Germany

16 (a) Informant Mrs Edna Goss
(b) Address 809 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Ave

18 (a) Funeral director John F Kleny Inc
(b) Address 716 Light St

19 AUG 30 1948 (Date filed by registrar) Registrar for Baltimore City

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29/1948 at 11:50 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-27 1948 to 8-28 1948 and that I last saw her alive on 8-28 1948

Immediate cause of death: Diabetes mellitus with acidosis + coma — Duration: ?

Due to: and Cardiovascular failure.

Due to: Arteriosclerosis, generalized Cerebrovascular accident

Other Conditions: Pulmonary thrombosis Myocardial thrombus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marguerite Louise Carlin M.D.
Address Maryland General Hospital Date signed 8/29

correct age is especially important. If unknown, give approximate age.

666285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 666285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Lloyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 28, 1872

8. AGE: Years 75 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER 12. Name John Lloyd
13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary K Piquett
15. Birthplace Baltimore

16 (a) Informant: Edwin Thomas Lloyd
(b) Address 713 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 31 48 (month, day, year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

16 (a) Funeral director Jas F Hegarty Inc
(b) Address 715 Light St

19 (a) AUG 30 1948 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1948, at 8:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Artery Disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George H. Merrill M.D. (Medical Examiner)
Date signed 8/28/48

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G66286

66286

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. .....

CERTIFICATE OF DEATH 21a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 E. Preston St.
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10-1
DIED AT HOME — KNOWN TO DR
(d) Length of stay in hospital or inst. (yrs., mos., or days) 52 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 44YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 E. Preston Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country .....

3 (a) FULL NAME Marie Crawford

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	MARRIED

6 (b) Name of husband or wife Robt. K. CRAWFORD
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr) JUNE 25, 1904

8. AGE: Years	Months	Days	If less than one day
44	2	4	hr. ..... min. .....

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business .....

FATHER
12. Name WM. F. DUEBEL
13. Birthplace MARYLAND

MOTHER
14. Maiden Name JULIA HENKLE
15. Birthplace MARYLAND

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Md.
Location .....

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) AUG 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 28 1948, to AUG. 29, 1948, and that I last saw her alive on Aug 28 1948.

Immediate cause of death	Duration
ADRENAL INSUFFICIENCY (Addison's Disease)	3 YRS
Due to TUBERCULOSIS of Adrenals	3YRS
Due to	
Other Conditions OLD INACTIVE APICAL PULMONARY TUBERCULOSIS (Include pregnancy within 3 months of death)	

Date of operation .....
Major findings of operation: .....
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury .....

23. Signature Samuel P. Asper, Jr. M.D. M. D.
Address JOHNS HOPKINS HOSPITAL Date signed Aug. 29, 1948

VS 150

66287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

191

Registered No. G66287

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 E. Hamburg St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George R. Mohler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of ~~husband or~~ wife Margaret L. Mohler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11th 1879

8. AGE: Years 69 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace West Virginia
(Town, county and state)

10. Usual Occupation Laborer

11. Industry or business Federal Tin Co

FATHER
12. Name Daniel V. Mohler
13. Birthplace W. Va.

MOTHER
14. Maiden Name Ann V. Morrison
15. Birthplace W. Va.

16 (a) Informant Margaret L. Mohler
(b) Address 300 E. Hamburg St.

17 (a) Removal (b) Date thereof 9/2/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or ~~crematory~~ Hedgesville
Location Berkeley Co. W. Va.

18 (a) Funeral director William Cook Inc.
(b) Address 1247 St. Paul St.

19 (a) AUG 30 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Aug 1948, at 9.25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Heat Stroke

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/28/48 at 6.30 P.M.
(b) Where did injury occur? Charles & Barre Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Industry While at work? yes
(d) Means of injury Heat Stroke

23. Signature Earl L. Royer M.D.
Medical Examiner

Date signed 29 Aug 48

666288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 666288

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John P. Purvis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of ~~husband or~~ wife Edith Barrat Purvis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1873

8. AGE: Years 74 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Phila. Pa.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Silversmith

FATHER
12. Name Robert Cranmer Purvis
13. Birthplace Pa.

MOTHER
14. Maiden Name Cecilia Dodge
15. Birthplace Pa.

16 (a) Informant Mrs Elizabeth Muffs
(b) Address 2027 N. Washington St.

17 (a) Burial (b) Date thereof 8/31/48
(Burial, cremation, or removal) (month, day, year)

(c) Cemetery ~~or crematory~~ Balto.
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) AUG 30 1948 (b) Twentytwo Williams, M.D.
(Date received by Registrar) Registrar

VS t81

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Aug 1948 at 6:17 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Coronary Atherosclerosis

Other Conditions Generalized A.S. Disease Fract. 3rd Cervical Vertebra
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl N. Royer M.D.
Medical Examiner.
Date signed 29 Aug 48

66289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 66289

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Hilton
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3432 Virginia ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Chomat

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Late Ignatz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1884

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Ruben Zenty
13. Birthplace Russia

MOTHER 14. Maiden Name Laura Russ (Died)
15. Birthplace Russia

16 (a) Informant Mrs. M. Foley
(b) Address 3432 Virginia Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 31 48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Belay Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North Ave.

19 (a) AUG 30 1948 (Date received by registrar)

Funeral Director Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Aug 1948 at 12:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1948 to 8/29 1948 and that I last saw her alive on 8/29 1948.

Immediate cause of death Respiratory Failure — Duration Known duration 5 days

Due to Carcinomatosis

Due to Carcinoma of the Stomach

Other Conditions Cachexia + Gastric bleeding
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Ca of Stomach & metastasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John J Tansey M.D.
Address St Agnes Hosp Date signed 8/29/48

Bull Med. x

6290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

Registered No. G66290

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Rd.
(c) Hospital or institution: Colonial Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 74 Yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 746 Grantley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Martin Gerbig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male

5 Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife 33/44

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 1874

8. AGE: Years 74 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph Gerbig
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Caroline ?
15. Birthplace ?

16 (a) Informant John Gerbig
(b) Address 746 Grantley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 30/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location 3801 Frederick Ave.

18 (a) Funeral director Frank Della Luca
(b) Address 322 S. High St.

19 (a) AUG 30 1948 (Registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Aug 1948, at 36. M

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Aug 1948 to 27 Aug 1948, and that I last saw alive on 26 Aug 1948.

Immediate cause of death: Acute Coronary Thrombosis — Duration

Due to: Hypertension C.V. Disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Earl L. Rogers M.D.
Address 172 Washington Blvd. Date signed 29 Aug 48

VS 150

666291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

666291 Registered No.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street 24
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 4
(c) City or town Baltimore 30 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 Covington Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: GEORGETTA SHECKELS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel F. Sheckels
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) April 28, 1888

8. AGE: Years 60 | Months 4 | Days — | If less than one day: hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Hunter
13. Birthplace Don't Know

MOTHER
14. Maiden Name Caroline Sheckels
15. Birthplace Balto Md

16 (a) Informant Samuel F. Sheckels
(b) Address 1528 Covington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Balto

18 (a) Funeral director C. Howard Evans
(b) Address 1410 Edmondson Ave

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 12:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1948, to Aug. 28 1948, and that I last saw her alive on Aug. 28 1948.

Immediate cause of death: Pathoplasiae Bronchopneumonia — Duration: 3 day
Due to: Adenocarcinoma
Due to: of Rectum
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation 8-25-48
Major findings of operation: Adenocarcinoma of Rectum
of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. E. Newell M. D.
Address 1213 Light St. Date signed 8-28-48

VS 150

66292
DCa F90592

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 129

Registered No. 666292

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23
(c) Hospital or institution: Sp H Balt. Bal. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David Chaffman

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1, 1943

8. AGE: Years	Months	Days	If less than one day
4	8	19	hr. min

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name David Henry Chaffman Jr.
13. Birthplace Balto Md

MOTHER
14. Maiden Name Jean —
15. Birthplace Balto Md

16 (a) Informant David Henry Chaffman Jr.
(b) Address 1732 Eastern Ave

17 (a) Burial (b) Date thereof Sept 1, 1948
(Burial, cremation, or removal)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director C. Howard Evans
(b) Address 1400 Shakspeare Washington, Wilmington, Del

19 (a) AUG 30 1948
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Aug 1948, at 4 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH acute peritonitis

Due to Upper Respiratory Infection

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 8/29/48

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

66293 ✓ Registered No. G66293

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1417 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Palmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Andrew Palmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 61 | Months: 3 | Days | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Isaiah Wesley
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary A. Reynolds
15. Birthplace: Md

16 (a) Informant: Andrew Palmer
(b) Address: 1417 W. Franklin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location

18 (a) Funeral director: James A. Stango
(b) Address: 1142 W. Pratt St

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1948 at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1948 to 8/28 1948 and that I last saw her alive on 8/28 1948

Immediate cause of death: Cerebral hemorrhage — Duration

Due to: Benign hypertension

Due to: Arterio sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature: Bruce Powell, Jr. M.D.
Address: Mercy Hosp, Date signed 8-29-48

X

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6294 — 48-05402 — 119a — 666294 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 N. Amity
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md County Balto
(b) City or town (If outside city or town limits, write RURAL and give town)
(c) Street No. 121 N. Amity St (If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

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3 (a) FULL NAME Guy M. Pinder

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-45

8. AGE: Years | Months 5 | Days 21 | If less than one day hr min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Edward Pinder

13. Birthplace md

MOTHER 14. Maiden Name Elizabeth Mason

15. Birthplace md

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31-45 (month)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director James A Stamps

(b) Address 142 W. Hill St

19 AUG 30 1945 (Name of city or registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Aug 1945, at 12 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute gastro-enteritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work)
(d) Means of injury

23. Signature Earl L Royer M.D. Medical Examiner

Date signed 29 Aug 45

VS 151

666295

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 666295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Do - Balto. Gen. Hospital
(c) Hospital or institution: 1200 Blk. Light St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 Jackson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA O. RUPP

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Thomas F. Rupp
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) March 21 1891

8. AGE: Years 57 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ludwig Otto
13. Birthplace Germany

MOTHER
14. Maiden Name Julliana Neuman
15. Birthplace Germany

16 (a) Informant Thomas F. Rupp
(b) Address 1626 Jackson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30 48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location Ritchie Highway

18 (a) Funeral director Richard Funeral Home
(b) Address 2 E. Chas St.

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Burlington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1948 at 6:50 PM

21. I certify that death occurred on the date above stated that I attended deceased from — 19 .. to 8/29 1948 and that I last saw her alive on 8/29 1948

Immediate cause of death Lobar pneumonia — Duration 2 days

Due to Dr

Due to

Other Conditions Diabetis mellitus — 6 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn O. Summerlin M. D.
Address 1213 Light St. Balto. 30. Date signed 8/29/48

108

correct age is especially important. Physicians: please write the clothes of death County ... registry.

VS 150

6296
AB-120206

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 49

Registered No. 666296

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2m 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 Elkins Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Knight

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7- 1873

8. AGE: Years 74 Months 8 Days 21 If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name David Robinson
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Zepp
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Road

18 (a) Funeral director Winston E. Donovan
(b) Address 3630 Poland Ave Huntington Woods, Mich.

AUG 30 1948
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28- 19 48 at 12.15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 6-5- 19 48. to 8-28- 19 48. and that I last saw her alive on 8-28-48 1948

Immediate cause of death Pulmonary metastases

Due to Ovarian adeno-carcinoma

Due to

Other Conditions Generalized arteriosclerosis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Kirken M.D.
Address Balto City Hosp. Date signed 30 Aug 48

66297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 66297

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3215 Dillon St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3215 Dillon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME CATHRINE [redacted] Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1864

8. AGE: Years	Months	Days	If less than one day
83	11	2	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Pete Hummel

13. Birthplace Germany

MOTHER 14. Maiden Name not known

15. Birthplace Germany

16 (a) Informant George H. Clark

(b) Address 3215 Dillon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/48 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location O'Donnell St

18 (a) Funeral director Clarence F. Hoffman

(b) Address 1639 Broadway

19 AUG 30 1948 (Date rec'd by Registrar) Huntington Notarius Mus

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 1948 at 8:00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-4 1946 to 8-26 1948 and that I last saw h[illegible] alive on 19

Immediate cause of death

Arteriosclerotic C. V. Disease — Duration 1942

Due to Myocardial Failure — 8-2-48

Due to Acute Coronary Occlusion. — 8 26 48

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence None at M

(c) Where did injury occur? None (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature E. A. Schimmel M. D.

Address 842 Eastern Date signed 8-27-48

VS 150

066298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 066298

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days): 8 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: --
(c) City or town: Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 3207 Ramona Ave., (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: METZGER, Boniface Joseph

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: -- Unknown

4. Sex: m

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Doretta E. Metzger

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 28, 1890

8. AGE: Years: 57 | Months: 11 | Days: 0 | If less than one day: - hr. - min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Fireman (Seafarer) - (American seaman)

11. Industry or business: Seafaring

FATHER
12. Name: Joseph Metzger
13. Birthplace: Germany

MOTHER
14. Maiden Name: Marie Ritter
15. Birthplace: Germany

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/31/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: North & Ross. Sts

18 (a) Funeral director: Clayton F. Kilhoffer
(b) Address: 1639 Broadway

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Huntington Williamson Md

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 28 19 48 at 4:06 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 19 48 to Aug. 28 19 48, and that I last saw him alive on Aug. 28 19 48

Immediate cause of death: Congestive heart failure — Duration: 7

Due to: Arteriosclerotic heart disease with auricular fibrillation. — Duration: 1

Other Conditions: Arteriosclerotic nephritis with azotemia — Duration:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Victor A. McKenzie
Address: U.S. Marine Hospital, Date signed: 8/28/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

93D

6299
AB-807147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

G66299
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 28 N. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Baranowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Frances (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 13- 1883-or 1884

8. AGE: Years	Months	Days	If less than one day
63 or 64		15	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Steel Worker

11. Industry or business

FATHER
12. Name John (D
13. Birthplace Poland

MOTHER
14. Maiden Name Ursala (D
15. Birthplace Poland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31-48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Balto. Co.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern ave

AUG 30 1948 (Date rec'd by registrar) (b) Farrington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28- 1948, at 1.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3- 1943, to 8-28- 1948, and that I last saw him alive on 8-28- 1948.

Immediate cause of death	Duration
Bilateral far advanced pulmonary tuberculosis & emphysema	
Due to	
Due to	
Other Conditions cerebral arteriosclerosis.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gayle B. Trueod M. D.
Address BCH - FB Date signed 29 Aug 48

X

066300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 121a

Registered No. 066300

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 418 E. Biddle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 "
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 418 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A. Sweeney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name David Sweeney
13. Birthplace Ireland

MOTHER 14. Maiden Name Ellen Ward
15. Birthplace Ireland

16 (a) Informant Mrs. G. Noffsinger
(b) Address 418 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St.

19 AUG 30 1948 (Date received by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Aug 1948, at 6.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 Aug 1948 to 28 Aug 1948 and that I last saw h[illegible] alive on 27 Aug 1948.

Immediate cause of death Uremia — Duration 3½ weeks

Due to Cardio-Vascular renal disease

Due to

Other Conditions Senile dementia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Silverfield M. D.
Address 714 E. Preston St Date signed 30 Aug

X

correct age is especially important. Physicians: please write the cause of death plainly.

VS 180

AMMENHAUSER

666301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666301

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto Co
(c) City or town Catonsville Md (If outside city or town limits, write RURAL and give town)
(d) Street No. Frederick Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. Ammenhauser

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 4-1894

8. AGE: Years 54 Months 7 Days 23 If less than one day hr. min.

9. Birthplace Balto Co Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Builder

FATHER
12. Name Oscar Ammenhauser
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Pfeiffer
15. Birthplace Md.

16 (a) Informant Mrs. Ceara Leicke
(b) Address 142 Collins ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto City Md

18 (a) Funeral director Edgar Mac Nabb
(b) Address Catonsville Md

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Washington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Aug 1948, at 5 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rogers M.D. Medical Examiner

Date signed 28 Aug 48

66302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66302

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give County)
(d) Street No. 502 S. Bradford St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ella Link (Alexsandra Link)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Leo David Link

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/5/95

8. AGE: Years 53 Months 3 Days 24 If less than one day hr. min.

9. Birthplace Locust Point, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Karol Dewgillo
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ? Unknown
15. Birthplace Unknown

16 (a) Informant Leo. D. Link
(b) Address 502 S. Bradford Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 AUG 30 1948 (Date rec'd by registrar) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1948 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26 1948 to Aug. 29 1948 and that I last saw h[illegible] alive on Aug. 29 1948

Immediate cause of death Broncho-pneumonia — Duration

Due to Cerebral Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Broncho-pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Guy C. Huston Jr. M. D.

Address St. Joseph Hospital Date signed Aug 29 1948

VS 150

G66303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66303

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 Lexington St.
(c) Hospital or institution: Fayette Nursing Home 28
(d) Length of stay in ~~hospital or inst.~~ (yrs., mos., or days) 1 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4119 HAYWARD AVE. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME ELSIE M. WILSON

3 (b) If veteran, name war: no
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, ~~or~~ divorced: widow
6 (b) Name of husband or ~~wife~~ Wm. —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) AUG. 24, 1877
8. AGE: Years 71 | Months - | Days 4 | If less than one day: hr. min.
9. Birthplace York, Pa. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Christian Lehman
13. Birthplace York, Pa.

MOTHER
14. Maiden Name Susana Hocke
15. Birthplace York, Pa

16 (a) Informant Mrs. Fannie C. Sadler
(b) Address 4119 Hayward Ave.

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ David Ridge
Location Pikesville

18 (a) Funeral director Wm. J. Tiernen & Sons
(b) Address 2 E. Pa. Ave.

19 (a) AUG 30 1948 (Date rec'd by registrar) Henrietta for Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1948 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21 1948 to Aug. 31 1948. and that I last saw her alive on Aug. 31 1948.

Immediate cause of death: Cerebral Hemorrhage Duration 7 da.
Due to Hypertension Duration ?
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Schaeffer M. D.
Address 75 E. Lexington Date signed Aug. 31 1948

correct age is especially important. a mistake

VS 150

66304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G66304
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2731 Parkwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr George Edward Raines

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	wh	

6 (b) Name of husband or wife Bessie F. Raines
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 30, 1887

8. AGE: Years	Months	Days	If less than one day
61	1	28	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name George E. Raines
13. Birthplace Va.

MOTHER
14. Maiden Name Ida F. Norwood
15. Birthplace Md.

16 (a) Informant Mrs. Bessie F. Raines
(b) Address 2731 Parkwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Pine Grove Cem.
Location Mt. Airy, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) AUG 30 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-48 19 , at 1:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1948 to 8-28 1948 and that I last saw him alive on 8-28-48 19

Immediate cause of death	Duration
Asphyxia due to	
Cerebral hemorrhage, coma	
Due to Hypertensive Cardio Vascular disease,	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert R. Young M.D.
Address Date signed 8-28-48

VS 150

G66305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G66305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 Scott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Henry H. Hawkins, Jr.

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1931

8. AGE: Years 16 | Months 11 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William H. Hawkins
13. Birthplace Balto.

MOTHER
14. Maiden Name Margaret Herkrotte
15. Birthplace Balto.

16 (a) Informant Mr. A. V. Hawkins
(b) Address 759 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/40 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 30 1940 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Aug 1940, at P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured Cervical Vertebrae (5th)

Due to

Other Conditions (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 27 Aug at M.
(b) Where did injury occur? Alpine Road Loudon Park Cem.
(c) Did injury occur at home, on farm, industrial place, in public place? While at work? No
(d) Means of injury Diving accident.

23. Signature M.D. Medical Examiner.
Date signed 28 Aug 40

VS 151

G66306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

463

G66306
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 E. 24th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis L. Peer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife George W. Peer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1888

8. AGE: Years 59 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Charles Vernon

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs. Muriel Perry

(b) Address 315 E. 24th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem.

Location Prince George's Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 19 48 at 7:14 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carcinoma of stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [illegible] Medical Examiner. M.D.

Date signed 8/29/48

VS 151

6307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 666307

13B

DB 121740

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Ohio~~ (b) County
(c) City or town ? (If outside city limits, give township) (and street town)
(d) Street No. 1520 Piper Henryton Sanatorium (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Odell Grice

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Alfonso
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1926

8. AGE: Years	Months	Days	If less than one day
22	7	2	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Milton Curry
13. Birthplace Ala.
14. Maiden Name Olbie Coleman
15. Birthplace Ala.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Youngstown Ohio
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St. Huntington West Va.

19 (a) AUG 30 1948 (Date received) Huntington West Va. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25- 1948 at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2- 1948 to 8-25- 1948, and that I last saw her alive on 8-25- 1948

Immediate cause of death	Duration
shock.	2 hours.
Due to Prolonged Levulose Pneumothorax	4 hrs
Due to Pulmonary TB	3 yrs
Other Conditions	

Date of operation 8-25-48
Major findings of operation: TB.
of autopsy: same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. Cook M. D.
Address 4940 Eastern Date signed 8-27-48

VS 15

66308 BC = C 322 K

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 184

Registered No. 666308

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 W. Franklin St.
(location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME
GARY SCROGGINS

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	—

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 30, 1945

8. AGE: Years	Months	Days	If less than one day: hr.	min.
2				

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Calvin Scroggins
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Evelyn Russell
15. Birthplace Balto. Md.

16 (a) Informant Evelyn Scroggins
(b) Address 727 W. Franklin St.

17 (a) Burial
(Burial, cremation, or removal)
(b) Date thereof Aug 30 1948
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) Aug 30 1948
(Date received by local registrar)
Katie R. Williams, Reg.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1948, at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of Brain -

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/25/48 at Approx. 1:30pm.
(b) Where did injury occur? above address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work)
(d) Means of injury. Firearms

23. Signature Carl L Royer M.D.
Medical Examiner
Date signed 8/26/48

66309

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 91a

Registered No. G66309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 Riggs Avenue
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Riggs Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Kelly Fleming

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel Worsley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1920

8. AGE: Years 28 | Months 5 | Days 5 | If less than one day: hr. min.

9. Birthplace: Greenville, N.C. (Town, county, and state)

10. Usual Occupation: Porter-University Hospital

11. Industry or business

FATHER
12. Name: John Fleming
13. Birthplace: Greenville, N.C.

MOTHER
14. Maiden Name: Rena Knox
15. Birthplace: Washington, D. C.

16 (a) Informant: Ethel Fleming (wife)
(b) Address: 1620 Riggs Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30, 1948 (month) (day) (year)
(c) Cemetery or crematory: National Cemetery
Location: Balto. Md.

18 (a) Funeral director: Mr. Katie R. Williams
(b) Address: 322 N. Schroeder St.

19 Aug 30 1948 (b) Katie R. Williams, Mgr.
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1948, at 10:25 A. M

21. I certify that I took charge of the remains described above, held an Partial Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Sub acute bacterial endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months preceding death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (What kind of work?)
(d) Means of injury

23. Signature: Carl Ruff M.D.
Medical Examiner.

Date signed 8-25-48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

666310

Registered No. 666310

666310

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Corner Lafayette & John. 14

(c) Hospital or institution:

Maryland for the Women of Maryland.

(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 4

(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) Not Known.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 230 W. Lafayette Ave
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Lehellenberg - (Marion Tennant Lehellenberg)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: WIDOWED

6 (b) Name of husband ~~or wife~~: Charles B. Lehellenberg

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) December 12, 1863

8. AGE: Years 84 | Months 8 | Days 19. | If less than one day: hr. min.

9. Birthplace Nova Scotia, Canada.
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER 12. Name John Carpen Tennant.

FATHER 13. Birthplace England

MOTHER 14. Maiden Name Marion Martin.

MOTHER 15. Birthplace Canada

16 (a) Informant Mrs. Frederick A. Kummer

(b) Address 230 W Lafayette Ave-Balto Md.

17 (a) Cremation (b) Date thereof 8-30-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Stewart & Company

(b) Address 108 W Monument

19 (a) Dec 30 1948 (b) Washington, D.C.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1948, to Aug 29 1948, and that I last saw her alive on Aug 29 1948.

Immediate cause of death: Bronchopneumonia — Duration: 4 da

~~Due to~~: Cardiac Vascular Accident — 1 week

Due to: Arteriosclerotic Cardiac Vascular Disease — not known

Other Conditions: Diabetes Mellitus — not known

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Findings above.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Mark E. Hall, M. D.

Address Womens Hospital Date signed 8/29/48

937

correct age is especially important. Physicians: please write the causes of death clearly, using words

G66311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G66311 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Howard St

(c) Hospital or institution: Maryland General

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give township)

(d) Street No. 11 East Centre St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hyman Fine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Clara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1873

8. AGE: Years 75 Months Days If less than one day hr. min

9. Birthplace Russia (town, county, and state)

10. Usual Occupation Field Manager

11. Industry or business

FATHER 12. Name Abraham

13. Birthplace Russia

MOTHER 14. Maiden Name Thanne

15. Birthplace Russia

16 (a) Informant Clara Fine

(b) Address 11 E Centre St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Jerman Hill Rd

18 (a) Funeral director Jack Levin Inc

(b) Address 2210 Eutaw Place

19 AUG 30 1948 (Date rec'd by registrar) (b) Washington Millman, M.D. Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Aug 1948 at 2.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Aug 1948 to 29 Aug 1948 and that I last saw him alive on 28 Aug 1948.

Immediate cause of death Acute Cardiac Failure Duration 4 days

Due to Hypertension and Arteriosclerotic cardio

Due to Cerebral Hemorrhage, with Decompensation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Emil M. Sternberg M.D.

Address 10 W Mt Royal Ave Date signed 29 Aug 48

66312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 666312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave 3-1
(c) Hospital or institution: West Balto General Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 Gleason Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID SCHLEIN

3 (b) If veteran, name war 1

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jeanette

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 73 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Moses

13. Birthplace Russia

MOTHER 14. Maiden Name Fannie

15. Birthplace Russia

16 (a) Informant Dept Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)

(c) Cemetery or crematory Baker Sharf

Location Mt Carmel

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Pl.

19 AUG 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1948 to Aug 30 1948; and that I last saw him alive on Aug 30, 1948.

Immediate cause of death: Acute pulmonary edema — Duration

Due to Coronary thrombosis - myocardial infarction

Due to Hypertensive arteriosclerotic heart disease

Other Conditions Benign prostatic hypertrophy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Lucher M.D.

Address West Baltimore Date signed Aug 30 '48

Gen Hosp. X

VS 150

66313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87

Registered No. 666313

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Mount Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3104 Troje Parkway (If rural give location)

(e) Citizen of foreign country (Yes or No)

If yes, name country

3 (a) FULL NAME Mildred Kemler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12

8. AGE: Years 36 Months Days If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Lemon

13. Birthplace Russia

MOTHER

14. Maiden Name Sophie

15. Birthplace Russia

16 (a) Informant Nathan Kemler

(b) Address 3104 Troje Parkway

17 (a) Burial, cremation, or removal Burial (b) Date thereof 8-30-48 (month) (day) (year)

(c) Cemetery or crematory Har Israel

Location Southern Ave

18 (a) Funeral director Jack Levy Inc

(b) Address 2109 Eutaw Place

19 (a) AUG 31 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30-1948 at 5:40 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 17, 1948, to Aug 30, 1948, and that I last saw deceased alive on Aug 30, 1948

Immediate cause of death

Septicemia — Duration days

Due to Infected Bed Sores — months

Due to multiple Abscess — years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. T. Krasnitsky M.D.

Address 3210 Liberty Hts Date signed Aug 31 48

VS 150

66314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 66314

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 E. East Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 E. East Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Powell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Robert Powell

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Sept 30 - 1872

8. AGE: Years 75 Months 11 Days 27 If less than one day hr. min.

9. Birthplace Germany. (Town, County, and state)

10. Usual Occupation At Home

11. Industry or Business

FATHER 12. Name Otto Kreger

FATHER 13. Birthplace Germany.

MOTHER 14. Maiden Name Unk.

MOTHER 15. Birthplace

16 (a) Informant Charles Doach

16 (b) Address Taylor Ave. Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31, 48 (month) (day) (year)

17 (c) Cemetery or crematory Mt. Carmel

Location O'Donnell St.

18 (a) Funeral director John J. Connelly.

18 (b) Address 46 Eastern Ave.

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27, 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 25 1948 to Aug 27 1948 and I that I last saw h alive on Aug 26 1948

Immediate cause of death Coronary Thrombosis — Duration 1 Week

Due to

Due to

Other Conditions

(Indicate if pregnancy complicated labor or death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny, D
Address 400 E Madison Date signed 2/30/49

VS 150

6663615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 V Registered No. 6663615

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 3912 Pulaski Highway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city limits, write RFD or give town)
(d) Street No. 3912 Pulaski Highway
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse L. Anders

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-1991

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Myrtle M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 18 1891

8. AGE: Years (57) | Months 7 | Days 2 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state) MD

10. Usual Occupation: Truck Loader

11. Industry or business

FATHER
12. Name: Jesse L Anders
13. Birthplace: Md

MOTHER
14. Maiden Name: Minnie M Cramer
15. Birthplace: Md

16 (a) Informant: Mrs M. M. Anders
(b) Address: 3912 Pulaski Highway

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof: 8/26/48
(c) Cemetery or crematory: Loraine
Location: Hagerstown Md

18 (a) Funeral director: Hilton Conn
(b) Address: 44 Public Sq Hagerstown Md

19 AUG 30 1948 (Date filed by registrar) Huntington Williams, Mgr

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/26/48 19 at 11 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection thereon and from the evidence obtained by said Autopsy / Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place?
(d) Means of injury

23. Signature: John R Davis M.D.
Medical Examiner
Date signed: 8/27/48

WITH CHIEF MEDICAL EXAMINER
FOR APPROVAL.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G666316

G6666

82

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyoming Ave near Edgewood
(c) Hospital or institution: Childrens Hospital School
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County PRINCE GEORGE
(c) City or town CLINTON, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME ROBERT ALLEN CRONE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-3-1947

8. AGE: Years 1 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace LA PLATA, PRINCE GEORGE, MD.
(Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business —

12. Name EVERETT ALLEN BOSWELL

13. Birthplace BRANDYWINE, MD.

14. Maiden Name FRANCIS ATKINS CRONE

15. Birthplace DANVILLE, VA.

16 (a) Informant EVERETT A. BOSWELL

(b) Address CLINTON, MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)

(c) Cemetery or crematory Columbia Mem. Park
Location Washington, D.C.

18 (a) Funeral director Wright Funeral Home

(b) Address 2008 Baltimore Blvd. Hyattsville for Childrens Hosp.

19 (a) AUG 30 1948 (Date received by Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1948 at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24 1948 to 8-28 1948 and that I last saw him alive on 8-28 1948.

	Duration
Immediate cause of death SHOCK	
DUE TO ACUTE INTESTINAL OBSTRUCTION	2 HOURS
Due to MEGA COLON	10 MOS.
POST-ENCEPHALITK	
Due to SPASTIC PARAPLEGIA	10 MOS
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation: 0

of autopsy: TORTION OF MEGACOLON

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature O. Donald Chrisman M. D.

Address Childrens Hospital School Date signed 8-29-48

For Robert B. Allen by Howard J. Masters, M.D.

VS 3

G66317 | 1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

Registered No. G66317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 Presstman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES ADDISON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2-41

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Addison
13. Birthplace Md

MOTHER
14. Maiden Name Margaret
15. Birthplace Md

16 (a) Informant Anna R. Marshall
(b) Address 3118 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month)
(c) Cemetery or crematory Mt Calvary
Location R. R. Co

18 (a) Funeral director Rayne Sanders
(b) Address 1412 E. Preston St

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1948, at 9.35a.m.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary artery disease
Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer, M.D. per: Howard J. Madden M.D. Medical Examiner.
Date signed August 27, 1948

VS 151

G663318 CUNNINGS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G663318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 427 Heaver St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 Heaver St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amos Cunnings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar 9-1902

8. AGE: Years 46 Months 5 Days 14 If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Green Cunnings

13. Birthplace Ga.

MOTHER 14. Maiden Name Nancy Cunnings

15. Birthplace Ga.

16 (a) Informant Annie Cunnings

(b) Address 427 Heaver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co.

18 (a) Funeral director Rayner Sanders

(b) Address 1411 E. Preston St

1948 AUG 30 1948 (b) (Date received by Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1948 to Aug 27 1948 and that I last saw h alive on 19

Immediate cause of death Pulmonary Tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

1 Yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. A. Johnson M.D.

Address 2329 Guilford Ave Date signed Aug 31 1948

Funeral Director Washington, D.C.

correct age is especially important; physician, please write

+

6319 C-673073 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 66319

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3208 WISTERIA AVE
(c) Hospital or institution: [redacted]
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 4
(e) Length of stay in Baltimore (yrs., mos., or days) 1YR 5 MOS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 WISTERIA AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH MARIE COUNTESS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1, 1947

8. AGE: Years 1 | Months 5 | Days 28 | If less than one day: hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business

FATHER 12. Name Edward W Countess
13. Birthplace Balto

MOTHER 14. Maiden Name Elizabeth [illegible]
15. Birthplace Balto

16 (a) Informant Edward Countess
(b) Address 3208 Wisteria Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.
Location Edmondson Avenue

18 (a) Funeral director Lilly & Zeily Funeral Home
(b) Address 403 S Fulton Ave

19 (a) AUG 30 1948 (Date received by registrar) Washington Wilkinson, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Aug' 1948, at 12:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 . and that I last saw h alive on 19

Immediate cause of death: Asphyxia due to aspiration of Vomitus

Due to Vomiting

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy: NONE

Duration: 30 minutes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide [redacted]
(b) Date of occurrence [redacted] at [redacted] M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature John A Toms M.D.

Address Date signed

X

666320 C-C50166 BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 666320

CERTIFICATE OF DEATH

24a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lemmon & Redwood Sts.
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 S. Coppleton St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty L. Burr

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife ✓ | 6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1946

8. AGE: Years 2 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William H. Burr
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Dora L. Godley
15. Birthplace Caroline Co.

16 (a) Informant Mrs William H Burr
(b) Address 406 S. Coppleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month, day, year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Belair Highway

18 (a) Funeral director John J. Bowman Son
(b) Address 900-03 Baltimore Street

19 (a) AUG 30 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1948 to Aug 28 1948 and that I last saw her alive on Aug 28 1948

Immediate cause of death Cardiac failure — Duration

Due to Septicemia ??

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Sborofsky M.D.

Address 609 N. Monroe St Date signed 8/31/48 M. D.

Registrar Thos. F. Ky

VS 150

Correct age is especially important

Ebeler

666321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

666321 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4026 N. Rogers Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 4026 N Rogers Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine L. Ebeler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Adolph A. Ebeler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13 1876

8. AGE: Years	Months	Days	If less than one day hr.	min.
72		15		

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Johnigen
13. Birthplace Germany

MOTHER
14. Maiden Name Hyknmat
15. Birthplace Germany

16 (a) Informant Harry H. Ebeler
(b) Address 4026 N. Rogers Ave

17 (a) Burial (b) Date thereof Aug 30 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Pauls
Location Druid Hill Park

18 (a) Funeral director Harry H. Amicarock
(b) Address 4704 Reisterstown Ave

19 (a) Aug 30 1948 (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1948 at 10:45 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of the bladder (urinary)

Due to

Other Conditions Cystitis Chronic Generalized
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. Waddell M.D.
Medical Examiner.
Date signed 8-29-48

VS 191

663322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 663322

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2505 E. Fairmount Ave.
(c) Hospital or institution:

6-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2505 E. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa K. Zapf

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Herman Zapf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1869

8. AGE: Years	Months	Days	If less than one day
79	3	22	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Daniel Pfennig
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Miller
15. Birthplace Germany

16 (a) Informant Miss Marie Zapf
(b) Address 2505 E. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 31/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Balto. Md.
18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.
19 (a) AUG 30 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28th 1948, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23rd 1948, to Aug 28th 1948, and that I last saw h[illegible] alive on Aug 28th 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 4 days
Due to arteriosclerosis
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Dix Taylor M.D.
Address 100 W. Miller Date signed 8/29/48

VS 189

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Harbold
66323

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C66323

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3316 Echodale Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3316 Echodale Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SUSAN ANN AMOS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Wm. Thomas Amos
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 29, 1859

8. AGE: Years	Months	Days	If less than one day
89	0	0	hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Thomas Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Carroll S. Amos
(b) Address 3316 Echodale Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory Bethel Cem.
Location Balto Co Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) AUG 30 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948 at 2:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Aug 29 1948 and that I last saw h alive on Aug 28 1948

Immediate cause of death Chronic Myocarditis — Duration ?

Due to Heart prostration Arteriosclerosis

Due to

Other Conditions uraemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold M.D.
Address 4706 Harford Road Date signed 8/30/48

VS 150

G66324

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

117a

G66324 Registered No. G 66324

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 38 Dunkirk Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LOUIS J.B. STURM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Mary Sturm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 29, 1887

8. AGE: Years	Months	Days	If less than one day
60	8	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles Sturm
13. Birthplace

MOTHER
14. Maiden Name Katherine Kaltenbach
15 Birthplace

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1, '48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director L.J. Ruck
(b) Address 5305 Harford Road

19 (a) 8/30/48 (Date rec'd by registrar) (b) Funeral Director for Williamsville

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 5:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1948 to Aug 28 1948, and that I last saw him alive on Aug. 28 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 15 hrs.

Due to: Hypertensive Cardio-vascular Disease — Duration: 21 mos.

Due to: — Duration: over

Other Conditions: Generalized Arteriosclerosis; Peptic Ulcer.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Li Pira M. D.
Address Mercy Hosp. Date signed 9-17-48

Chairman of Surg. Staff
Attended Nellie D. Wise - Asst. 938

Dr. Brennan

66525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 66525

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3109 Gibbons Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3109 Gibbons Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorothea Kinlein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Henry Kinlein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1859

8. AGE: Years	Months	Days	If less than one day
89	1	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George Stengel
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Glotzbach
15. Birthplace Germany

16 (a) Informant Mrs. Thomas Maskell
(b) Address 3109 Gibbons Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Rauck
(b) Address 5305 Harford Road #14

19 (a) AUG 30 1948 (Date received by Registrar) Thomas Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Aug 1948, and that I last saw her alive on July 1948.

Immediate cause of death Carcinomatosis — Duration

Due to Primary Carcinoma of left breast.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Brennan M.D.
Address 5217 Harford Rd Date signed 8-29-48

VS 150

Dr. Harbold
666326

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124a

Registered No. 666326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4614 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4614 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Basehart

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1886

8. AGE: Years	Months	Days	If less than one day
62	0	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Basehart
13. Birthplace Balto.

MOTHER
14. Maiden Name Mattie Frostburg
15. Birthplace Holland

16 (a) Informant Mr. Harvey J. Basehart
(b) Address 4614 Harford Road [illegible]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Baltimore, Maryland

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road [illegible]

19 (a) Filed (b) Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1948, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16 1948 to Aug 26 1948 and that I last saw h[illegible] alive on Aug 26 1948.

Immediate cause of death Chr Myocarditis — Duration 10 yrs

Due to Arteriosclerosis (generalized)

Due to Alcoholism

Other Conditions Cirrhosis Liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. V. Harbold M.D. M. D.
Address 4206 Harford Road Date signed 8/27/48

92D

VS 150

C66327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. C66327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2802 Evergreen Ave
(c) Hospital or institution D.O.A.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city limits, write RURAL and give town)
(d) Street No. 2802 Evergreen Ave
(If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Hervey B. Foutz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Ella M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 9-1865

8. AGE: Years 82 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Solomon Foutz
13. Birthplace Md

MOTHER 14. Maiden Name Miriam Cook
15. Birthplace Md

16 (a) Informant Mrs. Ella M. Foutz
(b) Address 2802 Evergreen

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48

(c) Cemetery or crematory Woodlawn
Location Balto

18 (a) Funeral director L. J. Lusk
(b) Address 5305 Harford Rd

19 (a) AUG 30 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1948 at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 mos. of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 8/30/48

VS 151

66328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66328

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Scars
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8421 Old Harford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank M Oppisich

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	(M)

6 (b) Name of husband or wife Margaret S.
6 (c) If single, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1-1890

8. AGE: Years 57 | Months 11 | Days 27 | If less than one day: hr. min.

9. Birthplace Balto - Maryland (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Navy Yard - Seal

FATHER
12. Name Louis Oppisich
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Hulsey
15. Birthplace Maryland -

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) AUG 30 1948 (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1948, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1948, to 8-28 1948 and that I last saw h alive on 8-28 1948

Immediate cause of death: Aspiration infection

Due to: Acute gastric dilatation

Due to: Carcinoma rectum

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-26-48

Major findings of operation: Carcinoma rectum resected

of autopsy:

Duration
Days
—

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Church Hosp. Date signed 8-30-48 M D

X

V3 190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666529

666529 ✓ 93

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4102 Idaho Ave. D.A.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4102 Idaho Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert E. Coggins

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) November 7, 1863

8. AGE: Years 85 | Months 8 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Baltimore Transit Co.

11. Industry or business Retired

FATHER
12. Name Robert Coggins
13. Birthplace Maryland

MOTHER
14. Maiden Name Amanda Cox
15. Birthplace Maryland

16 (a) Informant Mrs. Elizabeth Coggins
(b) Address 4102 Idaho Avenue -6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) AUG 30 1948 (Date rec'd by Registrar) ... Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1948 at 1:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Tubraske M.D.
Medical Examiner.
Date signed 8/29/48

X

666530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

✓ 666530 Registered No.

BC. 48-18892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 McElderry Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 McElderry Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred J. Common FREDDIE JAMES CARMON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-23-47

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Freddie James Carmon
13. Birthplace North Carolina

MOTHER
14. Maiden Name Geraldine Grady
15. Birthplace North Carolina

16 (a) Informant: Artemus Grady
(b) Address 1210 McElderry Court

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County

18 (a) Funeral director Wm. R. Elliott & Daughter
(b) Address 1121 N. Carrollton Ave.

19 (a) Aug 30 1948 (b) Frances Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Aug 1948; at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital Atelectasis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 24 Aug 48

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G66331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

✓ G66331

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 Laurens St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) No 14-3

(e) Length of stay in Baltimore (yrs., mos., or days) 64 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Laurens St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Anna Austin

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-22-6361

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife James Allen Austin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1884

8. AGE:	Years	Months	Days	If less than one day
	64	5	13	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Charles Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Clark
15. Birthplace Md.

16 (a) Informant William Blunt
(b) Address 516 Laurens W

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park
Location Halethorpe Md.

18 (c) Funeral director George T. O. Gibson Sr.
(b) Address 1735 Druid Hill Ave

19 (a) (b)
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 19 48 at 10 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 19 48 to Aug 27 19 48 and that I last saw her alive on Aug 27 19 48

Immediate cause of death Cardio Vascular Renal Disease — Duration 8 mo's

Due to Anemia — Duration 3 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Tracy M. D.
Address 1928 Penna Ave Date signed 8/27/48

VS 180

correct are to especially important. Physicians: please write all items carefully

G66332

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66332 51B Registered No. 369

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 Stockton St
(c) Ho[illegible] or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Stockton St. (If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Gonzin Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mamie Gray
6 (c) If alive, give age 53 years

7. Birth date of deceased mo., day, yr 1890

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Bowie Md (Town, county, and state)

10. Usual Occupation Plaster + Powder mixer

11. Industry or business

FATHER
12. Name George Gray
13. Birthplace Bowie Md

MOTHER
14. Maiden Name Mary H. Kyles
15. Birthplace Bowie Md

16 (a) Informant Mrs Mamie Gray
(b) Address 1119 Stockton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Md

18 (a) Funeral director Geo. B. Kelly
(b) Address 1303 Pennsylvania Ave

AUG 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-1948, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1 1948, to 8-28 1948, and that I last saw him alive on 8-27 1948.

Immediate cause of death Carcinoma of prostate — Duration 4 mos approx

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanton Saunders M. D.
Address 1029 N. Stricker St Date signed 8-28-48

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X

G66633

BALTIMORE CITY HEALTH DEPARTMENT ✓ G66633
Registered No.

CERTIFICATE OF DEATH 135B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2028 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William John Oliney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	M

6 (b) Name of husband or wife Mrs Carrie Oliney
6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr) ? 74

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Preacher
11. Industry or business Religious

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant: Wm T Long (step son)
(b) Address 1619 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location, Md

18 (a) Funeral director Ely. S. Kelsey
(b) Address 1303 Pressman St.

AUG 30 1948 (Date rec'd by registrar) Twentington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27 — 1948, at 10:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27-1948 to 8-27-1948, and that I last saw h[illegible] alive on 8-27-1948

Immediate cause of death Cardiac failure — Duration

Due to Pyrexia, uremia

Due to [illegible]

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature A M Purcell M.D.
Address Mercy Hospital Date signed 8-28-48

VS 150

G66334 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G66334 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street 25
(c) Hospital or institution: South Baltimore General Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 4
(c) City or town Baltimore 25
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cor. Hanover St. & Bristol Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MILTON SCHILLING

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/12/1899

8. AGE: Years	Months	Days	If less than one day
48	8	15	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Funeral Director
11. Industry or business Owns
FATHER 12. Name Wm. H. Schilling
13. Birthplace Md.
MOTHER 14. Maiden Name Mary E. Cook
15. Birthplace Md.
16 (a) Informant Family
(b) Address 3914 Hanover St.
17 (a) B. (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood.
Location Parkville
18 (a) Funeral director L. C. Cauley
(b) Address 1302 Fort Ave.
19 (a) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1948, at 1.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948, to Aug 27 1948, and that I last saw him alive on Aug 27 1948.

Immediate cause of death Generalized Peritonitis

Due to Perforation of Colon

Due to Carcinoma Splenic Flexure of Colon

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-14-48, 8-12-48

Major findings of operation: Carcinoma of Splenic Flexure of Colon

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. A. Reuwee M. D.
Address 1213 Light St. Date signed 8-27-48.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

G66335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G66335 Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2738 E Baltimore
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2738 E Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Ella Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17 1859

8. AGE: Years 89 | Months 9 | Days 11 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Oyster Retir ed
11. Industry or business

FATHER
12. Name: Dont Know
13. Birthplace

MOTHER
14. Maiden Name: Dont Know
15. Birthplace

16 (a) Informant: Mrs Elizabeth Somers
(b) Address: 2738 E Baltimore St

17 (a) (Burial, cremation, or removal) Burial (b) Date thereof (Day) Aug 31 1948

(c) Cemetery or crematory: Parkwood
Location: Balto Co Md

18 (a) Funeral director: Ullrich Funeral Home
(b) Address: 2008 Orleans

19 (a) 30 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 9 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1947 to Aug 28 1948, and that I last saw him alive on Aug 28 1948

Immediate cause of death: Uremia — Duration: 8/28/48
Due to: Chr. Myocarditis — 1/1/47
Due to: Senile Arterio Sclerosis — 1/1/1938
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: William J. Brown M.D.
Address: 501 N Kenwood Ave Date signed: 8/29/48

VS 150

G66336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G66336

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 N Castle
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N Castle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Scarborough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Scarborough
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr) Nov 8 1888

8. AGE: Years 59 | Months 9 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Yardman

11. Industry or business Establishment

FATHER
12. Name Wm Scarborough
13. Birthplace Balto

MOTHER
14. Maiden Name Mary Repp
15. Birthplace Md

16 (a) Informant Elizabeth Scarborough
(b) Address 519 N Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 (month) (day) (year)
(c) Cemetery or crematory Balto City
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2108 Edmondson Ave

8 30 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28th 19 , at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1948 to Aug 27 1948, and that I last saw him alive on Aug 27 1948

Immediate cause of death

Carcinoma of Pancreas — Duration 10 mos.

Due to

Due to

Other Conditions Pulmonary Embolism
(Include pregnancy within 3 months of death)

Date of operation Aug 29/48

Major findings of operation: Carcinoma of Head of Pancreas

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, industrial place, etc.)
(e) Means of injury

23. Signature Frank J. Ayd M. D.

Address 2005 Edmondson St Date signed 8/29/48

G66337

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66337 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 Milliman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1910

8. AGE: Years: 48 | Months | Days | If less than one day: hr. min.

9. Birthplace Ala. (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name Jo Davis
13. Birthplace Ala.

MOTHER 14. Maiden Name Fannie Mae Davis
15. Birthplace Ala.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30-1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Baltimore Md

18 (a) Funeral director Edward O. Wilson
(b) Address 1017 Bentley ave

19 (a) Date received by registrar Aug 30 1948 (b) Registration No. Harrington for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1948 to 8-26 1948, and that I last saw him alive on 8-26 1948.

Immediate cause of death Cerebrovascular accident — Duration: 20 min

Due to arteriosclerosis and Syphilis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work) (Specify type of place)
(e) Means of injury

23. Signature Richard S Ross M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 8/26/48

G66338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

G66338
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provt. Balto. General 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED.
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 Bishop Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Atkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years (Over 1 year) 57 | Months | Days | If less than one day: hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Chauffer
11. Industry or business

FATHER
12. Name Sandy Atkins
13. Birthplace Va

MOTHER
14. Maiden Name Alatha Atkins
15. Birthplace Va.

16 (a) Informant Mrs Florine Atkins
(b) Address 216 Va Bishop ave

17. (a) Burial, cremation, or removal Burial (b) Date (month) (day) (year)
(c) Cemetery or crematory Blackstone Cem
Location "

18 (a) Funeral director Elroy O Wilson
(b) Address 1020 E Brantley Ave

19 (a) Date rec'd by registrar (b) Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-1928, at 20 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Pelvis
Ruptured urinary bladder
Due to Ruptured gut.

Other Conditions Acute Peritonitis
(Include pregnancy within 3 months of death.)

If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-27-28 at 11.05 A.M.
(b) Where did injury occur? Fenwick: Belgian Rd, nr Thomas Run
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? yes
(d) Means of injury Struck auto. Thrown over.

23. Signature Howard J. Mackey M.D.
Medical Examiner.

Date signed 8-28-28

X

G666339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96

G666339

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 414 E Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-5
(e) Length of stay in Baltimore (yrs., mos., or days) 5y

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 E Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Doe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Jon Doe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years 56 | Months 9 | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Henry Beyby
13. Birthplace Md

MOTHER 14. Maiden Name Kate
15. Birthplace A. A. Co, Md

16 (a) Informant Nita Smith
(b) Address 414 E Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 49 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A A Co Md

18 (a) Funeral director Robt E Hutchinson
(b) Address 515 McCulloh St

19 (a) [illegible] (b) [illegible]
190 93E

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27th 1949 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 49 to Aug 27 1949.
and that I last saw h[illegible] alive on Aug 27 1949.

Immediate cause of death Acute Lobar Pneumonia — Duration 24 hrs

Due to Congestive Heart Failure — Duration 1 week

Due to Essential Hypertension

Other Conditions Arteriosclerosis Diabetes Mellitus Chronic Hypertrophic Arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Emerson L Julian
Address 1207 Madison Ave Date signed 8/27/49

Correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

G66340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G66340 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1221 Cloverdale Rd
(c) Hospital or institution: D-1A

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore C. Ky 3
(If outside city or town limits write RURAL and give town)
(d) Street No. 1221 Cloverdale Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-1880

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Beatrice B. Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 1, 1896

8. AGE: Years 52 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John H. Brown
13. Birthplace W. Va.

MOTHER
14. Maiden Name Rebecca Hill
15. Birthplace W. Va.

16 (a) Informant Mrs. Beatrice B. Brown
(b) Address 1221 Cloverdale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)

(c) Cemetery or crematory National Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Baltimore St., Md

AUG 30 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948 at 3:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration
Hypertrophy + dilatation
of the heart
Mitral insufficiency

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 8/27/48

VS 131

G66341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 D

Registered No. G66341

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith Street
(c) Hospital or institution:
Convent of Notre Dame 10 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith Street (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country County Cavan, Ireland

3 (a) FULL NAME Sister Laura Monaghan
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1878

8. AGE: Years	Months	Days	If less than one day
70	2	11	hr. min.

9. Birthplace County Cavan, Ireland (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name Philip Monaghan
13. Birthplace County Cavan, Ireland

MOTHER
14. Maiden Name Rose Fitzpatrick
15. Birthplace County Cavan, Ireland

16 (a) Informant Sr. M. Stan. Kostka
(b) Address 901 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore, Md.

18 (a) Funeral director Wm. P. Fenlon
(b) Address 1727 W. Baltimore St.

19 (a) AUG 30 1948 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 3.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1936, to Aug. 29 1948, and that I last saw her alive on Aug. 28 1948.

Immediate cause of death	Uremia	Duration
Due to	Hypertension	
Due to	Arteriosclerosis Myocardial degeneration	
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis J. Kurtz, M. D.
Address 110 E. North Ave. Date signed 8/30/48

correct age is especially important. Physicians, please write plainly and use no abbreviations.

G66342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66342 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2326 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2326 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William W. Morrison

3 (b) If veteran, name war: Spanish War & World War I

3 (c) Social Security Account No. 201-18-9903

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret E. Morrison

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr) 7-13-1881

8. AGE: Years 67 | Months 1 | Days 15 | If less than one day: hr. min.

9. Birthplace: Rochester N. Y. (Town, county, and state)

10. Usual Occupation: U. S. Army

11. Industry or business: Retired

FATHER
12. Name: Joseph Morrison
13. Birthplace: Rochester N. Y.

MOTHER
14. Maiden Name: Harriet Hatfield
15. Birthplace: Rochester N. Y.

16 (a) Informant: Margaret E. Morrison
(b) Address: 2326 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Natl.
Location: Frederick Road

18 (a) Funeral director: John J. Milby Inc.
(b) Address: 2121 E. Oliver St.

19 (a) AUG 30 1948 (Date rec'd by registrar) (b) Huntington Holidaysburg, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2-1948 to 8-28-1948 and that I last saw alive on Aug 26 1948

Immediate cause of death: Myocarditis
Duration: 3 wks

Due to: Arteriosclerosis
Duration: 5 yrs

Due to: Emphysema
Duration: 5 yrs

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Erik H. Printzmann M. D.
Address 9858 Reisterstown Rd. Date signed 8-29-48

VS 150

G66343

BC- 4P-18588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G66343

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5304 Nuth Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Boy Boy Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/29/48

8. AGE: Years | Months | Days | If less than one day 12 hr. 7 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Edward W. Jones
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Loretta Prasch
15. Birthplace Baltimore, Md.

16 (a) Informant Loretta Jones
(b) Address 5304 Nuth Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto Md

18 (a) Funeral director Leonard J. Rock
(b) Address 530 Park Ave

19 (a) AUG 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948 at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Aug 27 1948 and that I last saw him alive on Aug 27 1948.

Immediate cause of death Circulatory Collapse — Duration 1 hr
Due to Concussion — Duration less
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury
23. Signature Vivian B. Bozman M.D.
Address Mercy Hosp. Date signed 8/30/48

VS 150

66344

SC-B 86944

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

74a

Registered No. G66344

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town SUNSET BEACH PASADENA R.D. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert L Brown Jr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 22, 1947

8. AGE: Years	Months	Days	If less than one day
1yr	2	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Herbert L Sr. Jr.
13. Birthplace Williamsport Pa

MOTHER
14. Maiden Name Anna T Mitchell
15. Birthplace Wash D.C.

16 (a) Informant Mrs Herbert L. Brown, Jr. Sr.
(b) Address Sun Set Beach, Pasadena, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn Md R.F.D.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

AUG 30 1948 Washington Nathanson
(Date Rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29/48 19 at 10 58 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 7/29 1948 to 8/29 1948 and that I last saw him alive on 8/29 1948.

Immediate cause of death	Duration
(a) Acute Lymphatic Leukemia & Terminal	
Due to (b) Massive Subdural & Subarachnoid	
Due to (c) Hemorrhage	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Strong Jr. M. D.
Address St Agnes Hosp Date signed Balto Md 8/29/48

G66345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66345
Registered No.

2006

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 28 N. Montford Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 28 N. Montford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS FOGEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1886

8. AGE: 62 Years | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Hungary
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Continental Can Co.

FATHER
12. Name John Fogel
13. Birthplace Hungary

MOTHER
14. Maiden Name Rosa Barbernitz
15. Birthplace Hungary

16 (a) Informant George M. Robinson
(b) Address 1103 Darley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd.

18 (a) Funeral director John H. Muller
(b) Address 2334 Jefferson St.

19 AUG 30 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29 1948 at 12:50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH unable to make diagnosis

Due to Putrefactive changes

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Tuttle M.D.
Medical Examiner.
Date signed 8/30/48

VS 151

G66646

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 83a

G66646
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 Gibbons Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME V. LESLIE ZENTZ

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Lillian T. Zentz
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1876

8. AGE: Years	Months	Days	If less than one day
71	10	7	____ hr. ____ min.

9. Birthplace: Adams Co., Pa. (Town, county, and state)
10. Usual Occupation: Mgr.
11. Industry or business: Hardware Co.

FATHER
12. Name: Aaron Davis Zentz
13. Birthplace: Adams Co., Pa.

MOTHER
14. Maiden Name: Margaret A. Kiser
15. Birthplace: Carroll Co., Md.

16 (a) Informant: Mrs. Lillian T. Zentz
(b) Address: 2604 Gibbons Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Filed AUG 30 1948 (b) Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29, 1948 at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1948 to 8/29 1948 and that I last saw h[illegible]alive on 8/29 1948.

Immediate cause of death: Respiratory Circulatory failure

Due to: Hypostatic Pneumonia

Due to: Cerebral hemorrhage

Other Conditions: Generalized Arteriosclerosis SES

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature: James Meta, M.D.
Address: 5106 Harford Rd. Date signed 8/30/48

VS. 199

G66347 BALTIMORE CITY HEALTH DEPARTMENT G66347
CERTIFICATE OF DEATH 122B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette, Johns STREETS
(c) Hospital or institution:
HOSPITAL FOR WOMEN OF MARYLAND
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 DA.
(e) Length of stay in Baltimore (yrs., mos., or days) 34 DA.

2. USUAL RESIDENCE OF DECEASED:
(a) State W. VA. (b) County —
(c) City or town CHARLESTON (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 GRANT ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA EDITH GIBSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEMALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife DAVID ROY GIBSON
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) JAN 10, 1891

8. AGE: Years 57 Months 8 Days 20 If less than one day hr. min.

9. Birthplace LEWISBURG, WEST VA. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name Andrew JOHN/ HUTCHISON
13. Birthplace Greenbrier Co W. VA.

MOTHER
14. Maiden Name Catherine MARY/ HUTCHISON
15. Birthplace Somerset Co, W. VA.

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/30/48 (month) (day) (year)
(c) Cemetery or crematory
Location Charleston, W. Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 AUGUST 1948 at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 26 JULY 1948 to 30 AUG. 1948 and that I last saw her alive on 30 AUG. 1948.

Immediate cause of death: CARDIO-RESPIRATORY FAILURE — Duration 8-12 HRS.

Due to TOXEMIA, EMACIATION — 22 DA.

Due to POST OPERATIVE WOUND INFECTION — 30 DA.

Other Conditions FECAL FISTULA; HYDROTHORAX, LEFT - CAUSE ?
(Include pregnancy within 8 months of death)

Date of operation JULY 29, 1948

Major findings of operation:
INTESTINAL ADHESIONS - GASTRITIS

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James N. McCord Jr.
Address Women's Hospital Date signed 8/30/48

VS 150

correct age is especially important. Physicians: please write and spell plainly.

G66348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G66348
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Community

4-2 DOA

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, give RURAL and unknown)
(d) Street No. 517 West Mulberry Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES A. GUYER

GUYER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18 1872

8. AGE: 75 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Harrisonburg Va
(Town, county, and state)

10. Usual Occupation Cigar Maker

11. Industry or business

FATHER
12. Name Peter Guyer
13. Birthplace Oak Bridge Va

MOTHER
14. Maiden Name Martha Kelly
15. Birthplace Harrisonburg Va.

16 (a) Informant William B. Lindsay
(b) Address Harrisonburg Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1st/48 (month)

(c) Cemetery Woodbine
Location Harrisonburg Va

18 (a) Funeral director Frank Dellinger
(b) Address 322 S. High St.

19 (a) AUG 30 1948 (Date rec'd by registrar) Harrisonburg, Va. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25/48 19 2.45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Deaver M.D.
Medical Examiner.
Date signed 8/26/48

VS 151

G66349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66649

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2223 Ramsay Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2223 Ramsay Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Leon Edwards

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George B. Edwards
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1867

8. AGE: Years 81 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Prince Georges County, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Austin L. Adams.
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Hatton
15. Birthplace Maryland

16 (a) Informant George B. Edwards
(b) Address 2223 Ramsay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Avenue

AUG 30 1948 (Date rec'd by registrar) Clinton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1948, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948, to Aug 28 1948, and that I last saw h-- alive on Aug 27 1948.

Immediate cause of death: Pulmonary Edema.
Due to: Cardiac vascular disease
Due to:
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or Town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Hatch M.D.
Address 251 W. Lafayette Ave. Date signed Aug 30/48

G66350

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G66350

472199

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 W. Fayette, St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME LEMON Shaw

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Col	married

6 (b) Name of husband or wife Rebecca Shaw
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr) 10-2-95

8. AGE: Years	Months	Days	If less than one day
52	10	26	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Dave Shaw
13. Birthplace N. C.

MOTHER
14. Maiden Name Roxie Hanner
15. Birthplace N. C.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 31-48 (month) (day) (year)
(c) Cemetery or crematory Rock Spring Branch
Location Wilson N. C.

18 (a) Funeral director Elroy S. Wilson
(b) Address 511 Robertson ave

AUG 30 1948 (Date rec'd by registrar) (b) Wilmington, N. C.

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 28 1948 at 5-25 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-24- 1948 to 8-28- 1948 and that I last saw him alive on 8-28- 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 4 days

Due to Hypertensive arterio-sclerotic vascular disease — 4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard S Ross
JOHNS HOPKINS HOSPITAL
Address Date signed 8/28/48

5351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 164a

✓ 666351

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Long Island, Babylon (If outside city or town limits, write RURAL and give town)
(d) Street No. 50 Oak Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Royal J. Field

3 (b) If veteran, name war

3 (c) Social Security Account No. 091-16-6488

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mabel G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1908

8. AGE: Years 40 | Months 2 | Days 20 | If less than one day: hr. min.

9. Birthplace Boston, Mass. (Town, county, and state)

10. Usual Occupation Chief Engineer

11. Industry or business

FATHER 12. Name Henry Field
13. Birthplace U.S.

MOTHER 14. Maiden Name Elizabeth Monroe
15. Birthplace U.S.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 9-3-48 (month, day, year)
(c) Name and location of cemetery or crematory: Removed to: Babylon Long Island, N.Y.

18 (a) Funeral director: Selwood Undertaking Co.
(b) Address 3911 Kirby Ave. Baltimore, Md.

AUG 31 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION A'

20. DATE OF DEATH August 30 19 48 at 10:43 M

21. I certify that I took charge of the remains described above, held an Inquest or Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation by hanging

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-30-48 at Approx. 8 A. M.
(b) Where did injury occur? B&O Wharf---Locust Point, Pier #3
(c) Did injury occur at home, on farm, industrial place, in public place? Wharf While at work? Yes
(d) Means of injury Hanged self by electric wire from drain pipe Quarters

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 8/30/48

VS 151

6352

JL - 122348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 666352

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 2710
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5120 Craig Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Fitzgerald

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1878

8. AGE: Years	Months	Days	If less than one day
69	11	22	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Kerns
13. Birthplace Pa.

MOTHER
14. Maiden Name Ruth McDowell
15. Birthplace Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1417 St. Paul St.

19 AUG 31 1948 (Date received by local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1948, at 9.15 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 23 1948 to Aug. 28 1948, and that I last saw her alive on Aug. 28 1948

	Duration
Immediate cause of death: Pulmonary edema	2 days
Due to: Hypertensive Cardio-vascular Disease	5 yrs.
Due to:	
Other Conditions: Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Anchor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Keating M.D.
Address Balto City Hosp Date signed 29 Aug 48

VS 150

6353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G66353
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2536 W. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2536 Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida May Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ John F. Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30th 1867

8. AGE: Years	Months	Days	If less than one day
81	3	29	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER	12. Name Darington Thomas
	13. Birthplace Md.
MOTHER	14. Maiden Name Annie E. Creighton
	15 Birthplace Md.

16 (a) Informant John F. Morris
(b) Address 2536 W. Fairmount Ave

17 (a) Burial (b) Date thereof 8/31/48
(Burial, ~~cremation~~, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (Date received by registrar) AUG 31 1948 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29th 1948, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 19 48 to Aug 28 19 48 and that I last saw h alive on 8/26 of 48

Immediate cause of death	Duration
Hypertensive Heart Disease	4 yrs
Due to Senility	
Due to	
Other Conditions Chronic Myocarditis	7 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. H. Cahn
Address 2145 W. Balto Date signed 8/30-48

VS 150

6354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G66354

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 N Belvedere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 N Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alma M Redford

3 (b) If veteran, name war: M
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wilhom A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 1905

8. AGE: Years 43 | Months 2 | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Honoza Valdivia
13. Birthplace: Cuba

MOTHER
14. Maiden Name: Mary N Heiler
15. Birthplace: Baltimore Md

16 (a) Informant: Wilhom A Redford
(b) Address: 1304 N Belvedere Ave

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Balto. Md.

18 (a) Funeral director: Wilhom Coll Jr
(b) Address: 1214 E Cold St

19 AUG 31 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1948, at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to Aug 29 1948, and that I last saw her alive on Aug 25 1948.

Immediate cause of death: Carcinoma of Cervix — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify which place)
(e) Means of injury

23. Signature: Edw G Harrison M.D.

Address 7051 Oakland Date signed 8/30/48

VS 150

X

66355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 666355

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 N. Eutaw St
(c) Hospital or institution:
4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 N. Eutaw St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacqueline M. Bartlett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23, 1938

8. AGE: Years	Months	Days	If less than one day
10	7	6	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James C Bartlett
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Blanche Durham
15. Birthplace Baltimore Md

16 (a) Informant James C Bartlett
(b) Address 300 N Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)

(c) Cemetery or crematory Western
Location Balto. Md.
Funeral director Wm Cook Inc.
Address 217 St. Paul st

AUG 31 1948 (Date rec'd by registrar) (Signature and title of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29 1948, at 1 1/2 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracrania hemorrhage

Due to

Other Conditions congenital spastic idiot

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D.
Medical Examiner.
Date signed 8-29-48

VS 181

53556

AB-97018

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

9-D

Registered No. 666356

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 32yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 West Kenwood Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Carl Frederick Saylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-24- 1882

8. AGE: Years 65 Months 11 Days 4 If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Benjamin F. Saylor
13. Birthplace Pa.

MOTHER
14. Maiden Name Anna Shober
15. Birthplace Pa.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)
(c) ~~Cemetery or~~ crematory Greenmount
Location Balto. Md.

18 (a) Funeral director The Cortelyou Co.
(b) Address 27 E. Lanvale St.

19 AUG 31 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 152

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948 at 2.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31- 1945 to 8-28- 1948, and that I last saw him alive on 8-28 1948

Immediate cause of death
Pulmonary edema
Due to Hypertensive Cardiovascular disease
Due to
Other Conditions Hypertensive chronic nephritis
(Include pregnancy within 3 mos. of death)

Duration

Date of operation
Major findings of operation:

of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Kerby
Address Balto. City Hosp. Date signed 30 Aug 48

6657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

666657
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Rd.
(c) Hospital or institution:
Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 E. Preston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLOTTE MAUDE SCHMIDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, Married, Widowed, Divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) February 25,1867

8. AGE: Years 81 | Months 6 | Days 4 | If less than one day: hr min

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Henry David Schmidt
13. Birthplace Unknown

MOTHER
14. Maiden Name Matilda H. (Unknown)
15. Birthplace Unknown

16 (a) Informant Calvin H. Yerby
(b) Address 2623 N. Charles Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St. Paul Street

19 (Date rec'd by registrar) AUG 31 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 2 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury, at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? What (work)?
(d) Means of injury

23. Signature Medical Examiner, M.D.
Date signed 8-30-48

VS 151

6358 ES102540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 666358

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 N. Rose St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Charles Nitchick
3 (b) If veteran, name war
3 (c) Social Security No.
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Aldia (nee Goulek)
6 (c) If alive, give age years
7. Birth date of deceased: mo. day yr Jan. 1, 1883
8. AGE: Years 65 Months 7 Days 27 If less than one day hr min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Nitchick
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Hardtwick
15. Birthplace Germany

16 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (c) AUG 31 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28- 19 48 at 5:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-5 19 46 to 8-28 19 48, and that I last saw him alive on 8-28- 19 48

Immediate cause of death: Bronchopneumonia, rt. lower lobe — Duration: 2 days

Due to

Due to

Other Conditions: arteriosclerosis, generalized, severe. — 10-20 yrs
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above.

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Vickers, M.D.
Address Balto City Hosp Date signed 28 Aug 48

VS 150

66559 BC-48 18347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

191

Registered No. 66559

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gloria Ann DeNeal

3 (b) If veteran, name war.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/27/48

8. AGE: Years	Months	Days	If less than one day
		1	20 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation N' Born Infant

11. Industry or business

FATHER 12. Name Jerry DeNeal

13. Birthplace Va

MOTHER 14. Maiden Name Gloria Chambers

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Gloria DeNeal

(b) Address 1416 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)

(c) Cemetery or crematory Cooksville Md

Location Md

18 (a) Funeral director George G. Wilson

(b) Address 130 Pressman St

19 AUG 31 1948 (Date rec'd by Registrar) Huntington Williamsville

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1948, at 11 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1948 to 8/29 1948, and that I last saw h alive on 8/29 1948

Immediate cause of death	Duration
Shock	
Due to Heat Stroke?	
Due to Excessive atmospheric temperature.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.

Address Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5560 BC-B 21806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

AB-122505 157a Registered No. 666560

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patricia Diggs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22-1945

8. AGE: Years: 3 | Months: 5 | Days: 7 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Robert Diggs
13. Birthplace Va.

MOTHER
14. Maiden Name Cleo Ashby
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lou A. Hadaad
(b) Address 1631 Druid Hill Ave.

19 Aug. 31 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29- 1948, at 1.23 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28-48 1948, to 8-29- 1948, and that I last saw her alive on 8-29- 1948.

Immediate cause of death: Anoxia with marked hyperpnoea — Duration: 1 da.
Due to Congenital unknown
Due to
Other Conditions: 1) Osteogenesis imperfecta 3 yrs. 2) Hydrocephalus
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William P. Kean M.D.
Address Baltimore City Hosp. Date signed Aug 30, 48

120a

VS 150

6661 ½

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 1-1a

Registered No. 666361

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2540 Mace Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2540 Mace Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Florence

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 13, 1867

8. AGE: Years: 81 | Months: 4 | Days: 15 | If less than one day: hr. min

9. Birthplace: Rockville, Md. (Town, county, and state)

10. Usual Occupation: Janitor

11. Industry or business

FATHER
12. Name: UKNOWN
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace: UNKNOWN

16 (a) Informant: Mrs. Rebecca Reddick
(b) Address: 5718 Lawton Street Detroit #8, Mich.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 31, 1948 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary Baltimore, Maryland.
Location

18 (a) Funeral director: Mrs. George H. Holland
(b) Address: 1631 Druid Hill Ave.

19 (a) AUG 31 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 28 1948 at 9 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1 1947 to Aug 28 1948, and that I last saw h alive on

Immediate cause of death: Cardio - renal disease — Duration: 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Mrs. A. Johnson
Address 2529 Jacques St. Date signed Aug 31 1948

VS 150

6362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 1[illegible]2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4615 Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4615 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME John A. MEAgher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	married

6 (b) Name of husband or wife EUNice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7 1892

8. AGE: Years 56 | Months | Days | If less than one day hr. 1 min

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Bureau Receipts
11. Industry or business

FATHER 12. Name John MEAgher
FATHER 13. Birthplace BALTimore

MOTHER 14. Maiden Name ?
MOTHER 15. Birthplace BALTimore

16 (a) Informant Eunice Meagher
(b) Address 4615 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1 - 48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave

18 (a) Funeral director L. C. Harle
(b) Address 1216 West St

19 (a) AUG 31 1948 (Date received by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1948, at 11[illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1941 to Aug 26 1948, and that I last saw h[illegible] alive on Aug 26 1948.

Immediate cause of death	Duration
Coronary Occlusion	1 hr
Due to Coronary Disease	7 yrs
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Fitzgibbons
Address 124 Medical Arts Bldg Date signed 8/31/48

3363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

Registered No. G66363

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2009 E. 30th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

4-6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 E. 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: HARRY CLAY MARTIN, Sr.

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Emma A. Chesney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 16, 1867

8. AGE: Years 80 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace: Chestertown, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business: Fire Department

FATHER
12. Name: John Martin
13. Birthplace: Md.

MOTHER
14. Maiden Name: Elmira Wilson
15. Birthplace: Md.

16 (a) Informant: Mr. Harry C. Martin, Jr.
(b) Address: 318 Radnor Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)
(c) Cemetery or crematory: Moreland Memorial Pk. Balto., Md.
Location

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29, 1948, at 8:50pm

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 1948, to Aug 29 1948, and that I last saw him alive on Aug. 29 1948.

Immediate cause of death: Uremia.

Due to: Arteriosclerosis
Chronic nephritis
myocarditis.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W. Wallace Weaver

Address 3114 N. Nan Ave. Date signed 8/31/48

VS 150

6364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

666364
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2905 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County Henrico
(c) City or town Richmond R.F.D. 14 (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth C. Baber (Baber)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Kemper W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13 1876

8. AGE: Years 72 | Months 6 | Days 17 | If less than one day: hr. min.

9. Birthplace: Henrico Co. Va. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: George Clarke
13. Birthplace: Va.

MOTHER
14. Maiden Name: Edith Woody
15. Birthplace: ### Va.

16 (a) Informant: Mrs. Arthur B. Selph
(b) Address: 2905 Edmondson Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)
(c) Cemetery or crematory: Oakwood Cemetery
Location: Richmond Va.

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: North & Pennsylvania Aves

19 (a) AUG 31 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30th 1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1948 to Aug 30 1948, and that I last saw h[illegible] alive on Aug 29 1948.

Immediate cause of death: Cerebral Haemorrhage — Duration: 1 day

Due to Generalized arterio sclerosis with hypertension.

Due to arterio sclerotic type of heart disease with hypertrophy

Other Conditions Myocardial insufficiency and congestive failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature W. Michel M. D.

Address 2901 Edmondson Ave Date signed Aug 30 1948

VS 150

5365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666365

107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2004 N Charles St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 N Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Goebel

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1860

8. AGE: Years 88 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Philadelphia Pa
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Goebel
13. Birthplace Unknown

MOTHER
14. Maiden Name Emma Unknown
15. Birthplace England

16 (a) Informant Jack W. Goebel
(b) Address 2304 Drummond Ave

17 (a) Burial
(Burial, cremation or removal)
(b) Date thereof 9/1/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Nelson & Son
(b) Address 1241 E Cold St

19 (a) AUG 31 1948
(Date rec'd by registrar)
(b) Courtesy for Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1948, at 1145 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Aug 1948, to 29 Aug 1948, and that I last saw him alive on 29 Aug 1948.

Immediate cause of death	Duration
Dehydration	24 hrs
Due to Bronchopneumonia bilateral	+ 2 days
Due to	
Other Conditions Advanced arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred B Goebel M. D.
Address 2843 St. Paul. Date signed 31 Aug 48

VS 150

6366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66366
Registered No.

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3541 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Irene Garrison

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Roy
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Oct 4 1880
8. AGE: Years 67 | Months 10 | Days 26 | If less than one day hr. min.
9. Birthplace Carroll Co Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Garner
13. Birthplace Carroll Co Md

MOTHER
14. Maiden Name Sallie Simmons
15. Birthplace Carroll Co Md

16 (a) Informant Mildred Hough
(b) Address 3541 Greenmount Ave

17 (a) Burial
(Burial, cremation, or removal)
(b) Date thereof 9/2/48 (month) (day) (year)
(c) Cemetery or crematory Lexington Park
Location Lexington Md

18 (a) Funeral director Mathews & Sons
(b) Address 1211 Eutaw Pl

19 (a) AUG 31 1948 Courtney for Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1948, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1947 to Aug 30 1948 and that I last saw her alive on Aug 29 1948.

Immediate cause of death Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, or place)
(e) Means of injury

23. Signature Jack J. Singer
Address 506 E. North Ave (Date signed 8-31-48)

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666367

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 434 W. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 434 W. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah C. White.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Milton N. White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 3, 1874

8. AGE: Years 74 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Indianna Mantley
15. Birthplace Va.

16 (a) Informant Miss Mattie F. White
(b) Address 434 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Jesse W. Redden
(b) Address 436 W. Biddle St.

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1948 at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1948 to Aug 26 1948 and that I last saw her alive on Aug 28 1948

Immediate cause of death: Cardiac Vascular Renal Disease — Duration ? ?

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Address 1432 Bend Hill Ave Date Aug 31 - 48

VS 150

correct as is especially important. Physicians, please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666368

3368 BC-C 55625 ✓ 128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 Mt. Olivet Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 Mt. Olivet Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeffrey Douglas Weal

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1946

8. AGE: Years	Months	Days	If less than one day
1	11	27	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Weal
13. Birthplace Md.

MOTHER
14. Maiden Name Kathryn Stotler
15. Birthplace Miss.

16 (a) Informant George Weal
(b) Address 124 Mt. Olivet Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31/48. (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Lutzke
(b) Address 4101 Edmondson Ave.

19 (a) AUG 31 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28/48. 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 19 46 to 8/28 19 48 and that I last saw h alive on 8/19 19 48

Immediate cause of death: Undetermined — Duration

Due to Has been chronically ill since birth.

Due to

Other Condition Clasping Gastric Fibrosis of Pancreas

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral Edema.

Birth

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson Gantt M. D.
Address 4E. 33rd St. Date signed 8/31/48

Howard J. Madgic, M.D. over

correct age is especially important. Physician: please write the cause of death clearly, using ordinary language.

6369 Wal 2 S

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45F

Registered No. G66369

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Charlestown (If outside city or town limits, write RURAL and give town)
(d) Street No. 558 Cagel Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Jones

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	~~White~~ Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-28-87

8. AGE: Years	Months	Days	If less than one day
61 60	2	28	hr. min.

9. Birthplace Mo. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Scott Jones
13. Birthplace Va

MOTHER 14. Maiden Name Mary Thomas
15 Birthplace Mo

16 (a) Informant J. H. H.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 30th 1948 (month) (day) (year)
(c) Cemetery or crematory Father Dietz Cemetery
Location St Louis Mo.

18 (a) Funeral director Blogowidow
(b) Address 1000 Brantley.

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Registrar for Wallace, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25- 1948 at 1237 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23- 1948 to 8-25 1948 and that I last saw him alive on 8-25 1948

Immediate cause of death: Cerebral Accident — Duration

Due to: Carcinoma of Tonsil — 3 yrs

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Apr 26, 1948

Major findings of operation: Carcinoma Tonsil

of autopsy: Radical neck dissection

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J C Handelsman M. D.
Address Johns Hopkins Hosp Date signed 8-25-48

66370 ✓ G66370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 13 1a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Forrest St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ethel Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	M

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 5, 1892

8. AGE: Years	Months	Days	If less than one day
56	1	23	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Chadwick Brown
13. Birthplace

MOTHER
14. Maiden Name Nancy Poole
15 Birthplace

16 (a) Informant Daniel Johnson (son)
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Baltimore Md

18 (a) Funeral director Elroy O Wilson
(b) Address 1820 Bartlett Ave. Lansdowne, Md.

19 (a) AUG 31 1948 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28, 1948 at 6:50 A.M

21. I certify that death occurred on the date above stated: that I attended deceased from 8-26-1948 to 8-28-1948, and that I last saw her alive on Aug 28, 1948

Immediate cause of death Cardiac Failure — Duration 5-7 days

Due to Hypertensive C.V. renal disease — years

Due to Essential hypertension — years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Di Pira M.D. (Filed M.O.)
Address Mercy Hospital Date signed 8-28-48

VS 150

3371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12a

✓ Registered No. G66371

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3019 Gwynns Falls Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 83-2-28

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 Gwynns Falls Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Bertha Laura Demuth

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or ~~wife~~ Charles H. Demuth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1865

8. AGE: Years 83 | Months 2 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Depser
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Witzgall
15. Birthplace Germany

16 (a) Informant Mrs. Lillie E. Broessel
(b) Address 3019 Gwynns Falls Parkway

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 8-31-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 (d) AUG 31 1948 (Date rec'd by registrar) (Signature) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 11.30

20. DATE OF DEATH August 28, 1948, at P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Aug 1948 and that I last saw h[illegible] alive on Aug. 15 1948.

Immediate cause of death Arteriosclerotic Cardiovascular disease — Duration 10 yrs

Due to Decubitus ulcer & sepsis decubitus — 3 mos

Due to Senile dementia — 7 yrs

Other Conditions Prostatectomy — 7 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hans B. H. Thomsen M. D.
Address 1135 Guilford Ave. Date signed 8-31-48

correct age is especially important. Physicians, please write distinctly.

VS 150

6372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H

Registered No. 666372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8hr. 20min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Longwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN W. WHITMORE

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-0762

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M.

6 (b) Name of husband or wife Armin Whitmore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 30, 1897

8. AGE: Years	Months	Days	If less than one day
51	6	30	hr. min.

9. Birthplace Gadsden, Alabama (Town, county, and state)

10. Usual Occupation Insulation Mechanic

11. Industry or business Chamberlin Co.

FATHER
12. Name Alex Whitmore
13. Birthplace Alabama

MOTHER
14. Maiden Name Cora Hogue
15. Birthplace Alabama

16 (a) Informant Mrs. Armin Whitmore
(b) Address 1609 Longwood St.,

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9-2-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director W. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) AUG 31 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to illuminating gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/29/48 at ? M.
(b) Where did injury occur? 1609 Longwood St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury four burners on on stove

23. Signature Earl M. Rogers M.D. (Medical Examiner)
Date signed 8/30/48

G66373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G66373

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 S. Madeira Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 S. Madeira Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Poland

3 (a) FULL NAME Katherine Zysk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Frank Zysk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Anthony Podlesny
13. Birthplace Poland

MOTHER 14. Maiden Name ?Leonora ?
15. Birthplace Poland

16 (a) Informant Mrs. Frances Gos
(b) Address 413 S. Madeira Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep. 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John J. Welsh
(b) Address 401 S. Chester Street

19 (a) AUG 31 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION 2.16

20. DATE OF DEATH Aug. 29, 48 19 , at PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1945 to Aug 29 1948, and that I last saw her alive on Aug 29 48.

Immediate cause of death ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — Duration 1/23/45

Due to

Due to

Other Conditions UMBILICAL HERNIA — ???

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Beth F. Arenza M. D.

Address 209 E. Chester St Date signed 8/30/48

VS 3

Correct age is especially important.

66574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. 666574

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3411 Rosedale Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Rosedale Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Rus

3 (a) FULL NAME Maurice M. Rubin
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ethel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 39 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Finance
11. Industry or business

FATHER
12. Name Herman
13. Birthplace Russia

MOTHER
14. Maiden Name Rose
15. Birthplace Russia

16 (a) Informant Ethel Rubin
(b) Address 3411 Rosedale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Location Owings Mills Road
Jack Kemp Inc

18 (a) Funeral director
(b) Address 2100 Eutaw Place

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30 1948, at 10 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1947 to 9/30 1948, and that I last saw him alive on 9/30 1948

Immediate cause of death: Carcinoma of lung with metastases — Duration: 1yr

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton B. Kirsh, M.D.
Address 2320 Eutaw Pl Date signed 8/30/48

VS-50

6375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 666375

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai 13-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Auchentorly Ter
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE GREENSPAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Saul

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 72 | Months | Days | If less than one day: hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Kettle
13. Birthplace Lith

MOTHER 14. Maiden Name Totee
15. Birthplace Lith

16 (a) Informant Ellis Kallert
(b) Address 3500 Auchentorly Ter

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 2400 Ontario Place

19 (a) Filed by Huntington Williams M.E. (Registrar) Baltimore
(b) Date received by Local Registrar AUG 31 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30-48 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28-48 1948 to 8-30 1948, and that I last saw h[illegible] alive on 8-30 1948.

Immediate cause of death: UREMIA — Duration

Due to: Renal Arteriosclerosis

Due to:

Other Conditions: Arteriosclerotic H.D.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Katz M. D.
Address 3mai (Hosp.) Date signed 8-30-48

VS-150

correct age is especially important. Physicians, please write plainly.

6376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. 666376

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3428 Hickory Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3428 Hickory Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Douglas A. Morrow.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 4 1940

8. AGE: Years	Months	Days	If less than one day
8	5	18	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Thomas A. Morrow Jr.
13. Birthplace Va

MOTHER
14. Maiden Name Loreen E. Humphreys
15. Birthplace N. C.

16 (a) Informant Thomas A. Morrow Jr.
(b) Address 3428 Hickory Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Paul E. Schenouth Jr
(b) Address 3615-17 Lochearn Ave.

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Livingston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Aug 29 1948 and that I last saw him alive on Aug 29 1948.

Immediate cause of death Carcinomatosis — Duration

Due to Sarcoma of Thymus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward F. Glassman M. D.

Address 4037 Gallis Rd. Date signed 8/31/48

VS 150

66377

AB-122354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH . 13

G66377

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals 18

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 903 Boyd St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathaniel Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9- 1928

8. AGE: Years	Months	Days	If less than one day
20	5	19	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER

12. Name Nathaniel Lee

13. Birthplace Md.

MOTHER

14. Maiden Name Elnora Floyd

15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St.

19 AUG 31 1948 Washington Williams Mort. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

PM

20. DATE OF DEATH August 28- 1948, at 11.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23- 1948, to 8-28- 1948, and that I last saw h im alive on 8-28- 1948.

Immediate cause of death Tuberculous meningitis — Duration 2 weeks

Due to

Due to

Other Conditions Tuberculous adenitis
Tuberculous pleural effusion
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Margaret A. Morgan M. D.

Address Balt. City Hosp. Date signed 8-30-48

VS 193

X

5378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G66378 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 716 N. Stockton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 N Stockton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillie Shannanhause Joshuaway.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Benjamin Joshuaway.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): March 13, 1895.

8. AGE: Years 53 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace: A. A. County, Md. (Town, county and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Shannanhause
13. Birthplace: Elizabeth City, N.C.

MOTHER
14. Maiden Name: Lilly Carter
15. Birthplace: Gloucester Co. Va.

16 (a) Informant: Rose Johnson
(b) Address: 716 N Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1, 1948. (month) (day) (year)
(c) Cemetery or crematory: Arbutus Memorial
Location:

18 (a) Funeral director: Mrs Katie R Williams
(b) Address: 32 [illegible]

19 (a) AUG 31 1948 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1948, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 1948 to 8-28 1948 and that I last saw h[illegible] alive on 8-27 1948.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	
Due to (b) Arteriosclerosis	1 yr
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

23. Signature W. Atwell Jones M. D.
Address 673 Forrest St Date signed 8-31-48

VS 150

66379 La 4005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136a

✓ 666379 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 Dunen 80
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 Myrtle Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Tucker Samuel Tucker

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Negro	Widower

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/4/84

8. AGE: Years	Months	Days	If less than one day
64	1	23	hr. min.

9. Birthplace Odessa Del (Town, county, and state) None
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Jennie Anderson
(b) Address 1003 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 822 N Edmondson Ave

19 (a) AUG 31 1948 (b) Baltimore, Md. (Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948 at 6 00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/14 1948 to 8/27 1948 and that I last saw h alive on 8/27 1948

Immediate cause of death
Uremia
Due to Chronic interstitial Nephritis
Due to Arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify kind of place) While at work?
(e) Means of injury

23. Signature E Gleman Walden M.D.
Address Provident Hosp Date signed 8/30/48

correct age is especially important. Physicians, please write the causes of death very plainly.

66380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G66330

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital DOA 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 870 W. Fairmount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RICHARD GASTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Bessie Gaston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1898

8. AGE: Years: 50 | Months | Days | If less than one day: hr. min.

9. Birthplace: Washington D. C. (Town, county, and state)

10. Usual Occupation: Waiter

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace

MOTHER 14. Maiden Name: Unknown

15. Birthplace

16 (a) Informant: Beatrice Harper

(b) Address: Jessup Station, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 2, 1948

(c) Cemetery or crematory: Mt. Auburn Cem

Location

18 (a) Funeral director: Mrs. Katie R. Williams

(b) Address: 322 N. Pennsylvania Ave.

19 (a) AUG 31 1948 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 1948, at 6:20 P.M.

21. I certify that I took charge of the remains described above, held an inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature: Earl L. Royston M.D. (Medical Examiner)

Date signed 30 Aug 48

VS 151

6381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

Registered No. 66381

1. PLACE OF DEATH:
(a) Baltimore City or Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

CERTIFICATE CORRECTED 3-17-54

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES LAYFIELD

3 (b) If veteran, name war

3 (c) Social Security Account No. 182-03-7052

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, divorced: Married

6 (b) Name of husband or wife Rose Ruth Layfield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16. 1910

8. AGE: Years 38 | Months 7 | Days 11 | If less than one day: hr. min.

9. Birthplace Salisbury Md (Town, county, and state)

10. Usual Occupation Helper Truck Driver

11. Industry or business Glove Factory

FATHER
12. Name Geo. J. Layfield
13. Birthplace Salisbury

MOTHER
14. Maiden Name (Ellen Knoble) HELEN M. NOBLE
15. Birthplace Salisbury

16 (a) Informant M. Raymond Layfield
(b) Address Randallstown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof
(c) Cemetery or crematory Pikesville M.E. Cemetery
Location Pikesville Md

18 (a) Funeral director A. E. Arthur
(b) Address Pikesville Md

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Permit to remove to Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1948, at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of heart.
Acute edema of lungs.
Due to Fatty degeneration of liver.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 8/28/48

VS 151

66382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

191

Registered No. G66382

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Lancaster
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME STEPHEN CIAPURA

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER
12. Name J. Ciapura
13. Birthplace Lithuania

MOTHER
14. Maiden Name Gaulc
15. Birthplace

16 (a) Informant Frances Ciapura
(b) Address 1707 Lancaster, St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Washington Ave Baltimore, Md
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28/48 19 . at 1049 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Hus death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Heat Stroke

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John P. Davis M.D.
(Medical Examiner)
Date signed 8/29/48

VS 151

666383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

666383 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 520 Wyanoke Ave
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 Wyanoke Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Kisling Kielinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Frank Krzyzanowski

13. Birthplace Poland

MOTHER 14. Maiden Name Baus

15. Birthplace Poland

16 (a) Informant Ruth Kisling

(b) Address 520 Wyanoke Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore Md

18 (a) Funeral director Fred W Ozarowski

(b) Address 1938 Eastern Ave

19 Aug 31 1948 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29, 1948, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15, 1948, to Aug. 29, 1948, and that I last saw h[illegible] alive on Aug. 29, 1948.

Immediate cause of death Coronary Thrombosis — Duration 1 hour

Due to Coronary Sclerosis — Duration 2 years

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Medical Arts Bldg Date signed 8/30/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1866

✓ 666384 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 700 W. 40th St. Balto, Md.

(c) Hospital or institution:

Home for Incurables

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs. 4 mos. 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs. 10 mos. 23 days Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 700 W. 40th Street (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Mr. William Thomas Solomon.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Emma Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 6, 1865

8. AGE: Years	Months	Days	If less than one day hr.	min.
82	10	23		

9. Birthplace Baltimore, Maryland (Town, county and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER 12. Name Benjamin D. Solomon,

13. Birthplace Baltimore, Maryland.

MOTHER 14. Maiden Name Ruth Hamilton

15. Birthplace Unknown

16 (a) Informant A. Lake

(b) Address 700 W. 40th St, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 1948 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Balto md

18 (a) Funeral director Henry W. Jenkins Sons Inc

(b) Address 490 5 Mech Road

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Huntington Ave Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948. at 12:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 1940. to 8/29 1948, and that I last saw him alive on 8/28 1948

	Duration
Immediate cause of death Arteriosclerotic Heart Disease	3 years
Due to Generalized Arteriosclerosis	15 years
Due to Bilateral Dupuytren	5 years
Other Conditions Hypertrophied Prostate Fracture Neck of Femur (Left) (3 Mos) (Include pregnancy within 3 months of death)	2 years

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence June 8 at 3:45 PM

(c) Where did injury occur? 700 W. 40th St. Balto. Md. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home For Incurables While at work? No (Specify type of place)

(e) Means of injury fell on lawn while walking

23. Signature W. Grafton Thropegen

Address 1 E Madison St Bldg. Date signed 8/29/48 M. D.

Howard J. Maddux, M.D.

VS 153

66385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 191

Registered No. G666385

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline
(c) Hospital or institution:
St. Joseph's 26 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23/4 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3728 Fait Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Mrs. Caroline W. Thomas Kehoe~~ (CAROLINE W. KEHOE)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-10-0962

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	MARRIED

6 (b) Name of husband or wife Thomas Jos. Kehoe
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1902

8. AGE: Years	Months	Days	If less than one day
45	9	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Wife.
11. Industry or business Own home

FATHER
12. Name JOHN JANNUSCH
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name ANNA K. SMITH
15. Birthplace BALTIMORE, MD.

16 (a) Informant THOMAS J. KEHOE
(b) Address 3728 FAIT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEM.
Location EASTERN AVE.

18 (a) Funeral director Charles S. Zeiler
(b) Address 901 S. Conkling St.

19 (a) AUG 31 1948 Washington Hollins Ave. M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1948, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29, 1948, to Aug. 29, 1948, and that I last saw her alive on Aug. 29, 1948.

Immediate cause of death Heart Stroke — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Slight hypertrophy of the heart, chronic

PHYSICIAN
Underline the cause to which death should be charged and state...

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Ray C. Persons Jr. M.D.
Address St. Joseph's Hosp. Date signed 8/29/48

VS 150

66386 Csl 2
28828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G66386

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1021 N Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Othelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-6-10

8. AGE: Years	Months	Days	If less than one day
37	8	22	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Jesse Brown
13. Birthplace Va

MOTHER
14. Maiden Name Ossie Carey
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 31/48 (month) (day) (year)
(c) Cemetery or crematory
Location Charlottesville Va.

18 (a) Funeral director Mrs Robert A. Ellis or Dye
(b) Address 1129 N. Carlin's St

19 AUG 31 1948 Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 26, 1948, at 8 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 16 1948 to 8 26 1948 and that I last saw h.. alive on 8 26 1948.

Immediate cause of death	Duration
Probable Pulmonary Embolus	1 min
Due to Tuberculosis	5 mo.
Due to Tuberculous Pneumonia	1 mo.
Other Conditions Diabetes Mellitus (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard S Ross M.D.
Address JOHNS HOPKINS HOSPITAL Date signed 8/26/48

VS 150

66387

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66387

1212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland [redacted] CALVERT ST.
(b) Street address [redacted]
(c) Hospital or institution: UNION MEMORIAL HOSPITAL.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
(c) City or town MIDDLE RIVER.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 BANK COURT, VICTOR VILLA
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK MARSHALL MERRITT.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 28 1936

8. AGE: Years 11 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace KENTUCKY. (Town, county, and state)

10. Usual Occupation SCHOOL BOY.

11. Industry or business

FATHER
12. Name STANLEY MERRITT.
13. Birthplace KENTUCKY.

MOTHER
14. Maiden Name EVA COY.
15. Birthplace KENTUCKY.

16 (a) Informant EVA C. MERRITT.
(b) Address 4 BANK COURT, BALT, 20, MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept (month) (day) 48 (year)

(c) Cemetery or crematory Location Lexington — Kentucky

18 (a) Funeral director Frank H. Seitz
(b) Address 3142 36 St

19 (a) AUG 31 1948 (Date received by Registrar) (b) Tomlinson Williamson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 31 1948 at 2:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from AUG 12 1948 to AUG 31 1948, and that I last saw him alive on AUG 30 1948.

Immediate cause of death CONGESTIVE HEART FAILURE. — Duration 19 d.

Due to CHRONIC GLOMERULO-NEPHRITIS — 2 yrs.

Due to

Other Conditions UREMIA HYPOCALCEMIA. — 1 mon.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature William E. Cowan M.D.
Address Union Mem Hosp Date signed 8-31-48

VS 180

666588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 666588

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Ballo
(c) City or town Sparks (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Abram L. Phillips

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Novella Dickson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1879

8. AGE: Years	Months	Days	If less than one day
69	6	11 10	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Asa Phillips
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. A. L. Phillips
(b) Address Sparks, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-48 (month) (day)
(c) Cemetery or crematory Douglas AME
Location Cockeysville, Md.

18 (a) Funeral director J. M. Brooks
(b) Address Sparks, Md.

19 (a) AUG 31 1948 (Date received by registrar) (b) Thurlington for Williams, M.D. Registrar

VS 19

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948, at 9:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? What was he doing at time of injury?
(d) Means of injury

23. Signature Earl Royston M.D. (Medical Examiner)
Date signed 8/31/48

66389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 666389

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1148 Ward St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1148 Ward St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE L. BENTZ GUBITOSE-ROSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife No record.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30th-1892

8. AGE: Years 55 | Months 7 | Days 28 | If less than one day: hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Geo. Bentz
13. Birthplace Frederick Md.

MOTHER
14. Maiden Name Sallie Howe
15. Birthplace Md.

16 (a) Informant John H. Benges
(b) Address 1148 Ward St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Lenburnie, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) AUG 31 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28th 1948, at 10 35 P.M.

21. I certify that I took charge of the remains described above, held an inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
myocardial degeneration

Due to

Other Conditions obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place or in public place? While at work?
(d) Means of injury

23. Signature Earl L. Ross M.D.
Medical Examiner.
Date signed 8/29/48

VS 151

G66390

ES-107010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

Registered No. G66390

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Balto. City Hospitals, 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 8 mo.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1907 W. Lombard St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora Hausman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S.

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1876

8. AGE: Years	Months	Days	If less than one day
71	11	23	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Christina Mansdorfer

MOTHER 15. Birthplace Md.

16 (a) Informant RECORDS- Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1, 1948 (month) (day) (year)

(c) Cemetery or crematory Westwood Baltimore

Location

18 (a) Funeral director Fairfield & Gode

(b) Address 1708 W. Lombard St.

19 AUG 31 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29 1948 at 5:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 12-21 1946 to 8-29 1948, and that I last saw him alive on 8-29 1948.

Immediate cause of death: Probable rupture of aortic aneurysm

Due to: Luetic cardiovascular disease

Due to:

Other Conditions: Arteriosclerosis generalized

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William H. Hunkins

Address Balto City Hosp Date signed 30 Aug 48 M. D.

Please write plainly, with pen or pencil, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 15

66391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. 666391

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) abt 76 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town City of Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 Park Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Reguard

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edward L. Reguard
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 17-1865

8. AGE: Years 82 83 | Months 3 8 | Days 16 14 | If less than one day: hr. min.

9. Birthplace Brunswick-Germany
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry M. Iler - (?)
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Edward F. Reguard (Son)
(b) Address 1921 Park Ave - City

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9-2-48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Stewart & Mower Company
(b) Address 108 West North Ave - City

19 (a) AUG 31 1948 Registrar — Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1948, at 4:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1948 to Aug 31 1948, and that I last saw h[illegible] alive on 28 aug. 1948.

	Duration
Immediate cause of death: Arteriosclerotic Hypertensive cardiovascular disease with cardiac failure	5 years +
Due to	
Due to	
Other Conditions: Carcinoma of Bladder	1yr +

(Include pregnancy within 3 months of death)

Date of operation April 48

Major findings of operation: Carcinoma of Bladder - Transplantation of ureters

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 20 E. Preston St - Balto. Md. Date signed 31 Aug 48

VS 150

correct age is especially important. Physicians: please write the cause of death plainly, and spell

G66392

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G66392

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 E. 25th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 ---
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 E. 25th Street (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No) If yes, name country -------

3 (a) FULL NAME GENEVIEVE L. WHITEFORD

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
About 67	--	--	-- hr. ---min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James Whiteford
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Riley
15. Birthplace Maryland

16 (a) Informant W. Hamilton Whiteford
(b) Address Title Bldg. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (yr.)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. H. Ulman and Son
(b) Address 1905 N. Calvert St.

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Thomas Worthington Williamson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1947 to Aug 30 1948, and that I last saw her alive on Aug 23 1948.

Immediate cause of death	Duration
Hypertension and Arteriosclerotic cardiovascular disease	3 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Kramer M.D. M.D.
Address 1402 E. Lanvale St. Date signed Aug 30 1948

VS 150

G66393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No. G66393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4737 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town).
(d) Street No. 4737 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James E. Dunn

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-12-4441

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Lucille
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Apr. 7, 1878

8. AGE: Years	Months	Days	If less than one day
70	4	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Laundry Foreman

FATHER
12. Name Samuel J. Dunn
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Catherine Carlyle
15 Birthplace England

16 (a) Informant Mrs. Lucille Dunn
(b) Address 4737 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (Month) (Day) (Year)
(c) Cemetery or crematory Loudon Park Cem.
Location

18 (a) Funeral director Young Byers
(b) Address 5005 Park Heights Ave

19 (a) AUG 31 1948 (Registered by registrar) (b) Kenneth Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 9:57 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1948, to August 29 1948 and that I last saw h[illegible] alive on Aug 29 1948.

Immediate cause of death
Carcinoma of Liver — Duration 3/6/48
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. A. Bullet M. D.
Address 1003 Park Heights Ave Date signed 8/31/48

VS 150

66394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G66394

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4020 Lewiston Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4020 Lewiston Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME M. Edna Andrews

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife Harry G. Andrews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1886

8. AGE: Years	Months	Days	If less than one day
62	3	19	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Milton Hood.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mozie Glascock
15 Birthplace Ky.

16 (a) Informant Mrs. Harry G. Andrews
(b) Address 4020 Lewiston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore 9, Md.

18 (a) Funeral director Loring Bruce
(b) Address 5005 Park Heights Ave

19 (a) Aug. 31 1948 (b) Huntington Williams, M.D.
(Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1948, at 11 00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Aug 29 1948
and that I last saw h[illegible] alive on Aug 29, 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive C. V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius C. Bruce M. D.
Address 5356 Reisterstown Rd No X Date signed 8/30/48

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66395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G66395
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 Cedarwood Rd. Catonsville
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Caton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 17, 1888

8. AGE: Years 59 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Mental nurse Man

11. Industry or business

FATHER 12. Name Michael J Caton (dec'd)
13. Birthplace Md

MOTHER 14. Maiden Name Anne Conner (dec'd)
15. Birthplace Md

16 (a) Informant Lillian E. Caton
(b) Address 14 S. Cedarwood Rd.

17 (a) Burial (b) Date thereof 9-2-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Baltimore & Fayette Sts.

19 (a) SEP 21 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1948, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28 1948 to 8/29 1948 and that I last saw h alive on 8/29 1948.

Immediate cause of death Myocardial infarction, acute
Due to pulmonary edema, complete heart block
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank D Wagner Jr. M.D.
Address St Agnes Hosp Date signed 8/29/48
Balto Md

VS 150

G66396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

Registered No. G66396

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2546 Wilkens Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2546 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Estella Corrigan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife George W.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) March 17, 1885

8. AGE: Years	Months	Days	If less than one day
63	5	12	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John J. McCumber
13. Birthplace Penn.

MOTHER
14. Maiden Name Anna Price
15. Birthplace Penn.

16 (a) Informant George W. Corrigan
(b) Address 2546 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave. & Fayette St.

19 (a) AUG 31 1948 (b)
(Date rec'd by registrar) Huntington Ave. Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1948, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Aug 29 1948, and that I last saw h[illegible] alive on Aug 28 1948.

Immediate cause of death	Duration
Pulmonary Oedema	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert C. Mitchell
Address 2557 Wilkens Ave Date signed 8/31/48

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G666397

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

Registered No. G666397

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1032 Hillen Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Forrest St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Canada (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name unknown

13. Birthplace " "

MOTHER 14. Maiden Name Adell Dennis

15. Birthplace Canada

16 (a) Informant Frances Mitchell

(b) Address 301 Forrest St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31-48

(c) Cemetery or crematory Mt Calvary Cem

Location Brooklyn Md

18 (a) Funeral director Elroy, Wilson

(b) Address 1005 Bloodly ave

19 (a) AUG 31 1948 (b) Huntingtor Williams, M

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Aug 1948, at 9:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Myocardial Degeneration

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. Medical Examiner

Date signed 29 Aug 48

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666398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 666398

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1202 Jefferson ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-1
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 Jefferson ST
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE YARBROUGH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Married

6 (b) Name of husband or wife Henry Yarbrough
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Sept. 6-1897

8. AGE: Years	Months	Days	If less than one day
50	11	24	hr. min.

9. Birthplace Wake Forest N.C.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Rob. Clement Dunn
13. Birthplace Wake Forest N.C.

MOTHER
14. Maiden Name Mary J. Dunn
15. Birthplace Louisburg N.C.

16 (a) Informant Henry Yarbrough
(b) Address 1202 Jefferson ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy S. Wilson
(b) Address 1001 Reisterstown Ave

19 AUG 31 1948 (b) Emmanuel Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948, at 5:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-9 1948, to 7-25 1948, and that I last saw her alive on 7-25 1948.

Immediate cause of death CARCINOMATOSIS

Duration 6 mo 2 wks

Due to CARCINOMA of BREAST

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris M. D.
Address 1824 W. Franklin St Date signed 8-30-48

PLEASE WRITE CLEARLY. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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666399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 666399

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 6-A
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 1st yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 613 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIE JENKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 47 (age) | Months | Days | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name John Jenkins
13. Birthplace N. C.

MOTHER 14. Maiden Name Jennie Edwards
15. Birthplace N. C.

16 (a) Informant Mildred Jenkins
(b) Address 613 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2-48 (month)

(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomsbury ave

19 (a) AUG 21 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948 at 11:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis
Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Reyle M.D.
Medical Examiner.
Date signed Aug 28 1948

VS 151

66400 JL - 59196

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61 Registered No. 66400

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Little Sister of the Poor (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Lynch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John Lynch (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 29, 1867

8. AGE: Years	Months	Days	If less than one day
81	5	29	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Hugh McVeigh
13. Birthplace Scotland

MOTHER
14. Maiden Name Catherine Noonan
15. Birthplace Balto, Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory St. John's Lo. Emg. Location Long Green, Md.
18 (a) Funeral director Charles L. Zeile
(b) Address 901 S. Conkling St.
19 (a) AUG 31 19 (Date rec'd by registrar) Huntington Williams, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1948 at 2.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14 1940 to Aug. 28 1948, and that I last saw her alive on Aug. 28 1948.

Immediate cause of death ? Coronary occlusion — Duration

Due to Arteriosclerotic Heart disease Ramicular fibrillation and failure

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David L. Marine M. D.
Address Balto City Hosps Date signed 8-31-48

VS 193

93D

66401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66401 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 Chapel Gate Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Chapel Gate Lane (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA M. KNABE

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John Knabe

6 (c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): July 10, 1877

8. AGE: Years: 71 | Months: 1 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Upton, Penna. (Town, county, and state)

10. Usual Occupation: At home

11. Industry or business

FATHER
12. Name: Neady
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Mr. John Knabe
(b) Address: 510 Chapel Gate Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/1/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location

18 (a) Funeral directors: Chas. J. Evans Sons Inc.
(b) Address: 18 W. Mt. Royal Ave

19 (a) Filed [illegible] 1948 (Registrar's signature) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 27 1948 to Aug 29 1948, and that I last saw her alive on Aug 29 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertension

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Samuel [illegible] M.D.

Address 2320 Eutaw Place Date signed 8/31/48

VS, 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66402

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3716 Brooklyn Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25+
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 Brooklyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith J. Philburn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Geo. A.
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr) Dec 14, 1907

8. AGE: Years	Months	Days	If less than one day
40	8	16	... hr. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at home

FATHER
12. Name Robert Dorsey
13. Birthplace Md

MOTHER
14. Maiden Name Queenie Harrison
15. Birthplace Md

16 (a) Informant Mr Geo A. Philburn
(b) Address 3716 Brooklyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Annapolis Blvd

18 (a) Funeral director John F Kenny Inc
(b) Address 716 Light St

19 (a) AUG 31 1948 (Date rec'd by registrar) (b) Pennington Hollowell, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948, at 3 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1947, to 8-30 1948, and that I last saw h alive on 8-30 1948.

Immediate cause of death: Chronic Myocardial Degeneration — Duration 8 yr.
Due to Rheumatic fever
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. A. Pollard, M.D.
Address 707 Fort Ave. Date signed 8-31-48

VS 15)

G66403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G66403
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County AA Co
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Hawkins St Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Logan Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Theona Johnson

6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) May 20, 1915

8. AGE: Years	Months	Days	If less than one day
33	3	11	hr. min.

9. Birthplace Ashland, Ky.
(Town, county, and state)

10. Usual Occupation Crain Operator

11. Industry or business Construction

FATHER
12. Name Charles N. Jackson
13. Birthplace Ky

MOTHER
14. Maiden Name Hazel Baer
15. Birthplace Ky

16 (a) Informant Mrs Charles Jackson
(b) Address 6400 Arundel Cove

17 (a) Burial (b) Date thereof 9/3/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Ashland Cem
Location Ashland, Ky

18 (a) Funeral director John F Feldmyer Inc
(b) Address 711 Light St

19 (a) AUG 31 1948 (b) Huntington, West Virginia, Mar
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31- 1948 at 3:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25- 1948 to 8-31- 1948 and that I last saw him alive on 8-31-1948

Immediate cause of death

Uremia
acidosis
Due to Chronic hypertrophic nephritis — Duration: 20 yr

Due to
Generalized arteriosclerosis
Other Conditions Diabetes mellitus
Arteriosclerotic heart Disease — Duration: 20 yr
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
—
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — — —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature William T. Hearn M. D.
Address South Balti Hos Hosp Date signed
Baltimore 30, Md 8/31/48

1310

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666404

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or [redacted] St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Towson, Rural Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Immaculate Conception Convent
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Sr. Mary Hortense, O.S.F.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/26/73

8. AGE: Years	Months	Days	If less than one day
74	11 10	4	hr. min.

9. Birthplace Wilmington, Del. (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name James Mc Donough
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Keenan
15. Birthplace Ireland

16 (a) Informant Mother M. Florinda O.S.F.
(b) Address St. Joseph Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 (a) 9-1 1948 (b) Name and title of registrar Thomas Joseph Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30, 1948 at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5, 1948 to Aug. 30, 1948 and that I last saw her alive on Aug. 30, 1948

Immediate cause of death	Myocardial Insufficiency	Duration
Due to	Asteno-Sclerotic Heart Disease	
Due to	Hypertensive Cardio-Vascular Disease	
Other Conditions (Include pregnancy within 3 months of death)	Cerebral Thrombosis	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ray E. Persons Jr. M.D.
Address St. Joseph's Hosp. Dated 8/30/48

correct age is especially important. Typewrite, if possible, or print plainly with pen and ink. Use no abbreviations.

VS 150

66405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 66405

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 436 S. Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 436 S. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie R. Dembinsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race W.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife William Dembinsky

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1889

8. AGE: Years 59 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert S. Wilson
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant William Dembinsky
(b) Address 436 S. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Ave.

18 (a) Funeral director Harry S. Little
(b) Address 4101 Edmondson Ave.

19 AUG 31 1948 (b) Huntington Williams, M.D. Registrar
(Date received by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29, 1948, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1948 to Aug 29 1948, and that I last saw her alive on Aug 26/48.

Immediate cause of death Trauma — Duration 2 weeks

Due to Chronic Nephritis — 20 Yrs

Due to

Other Conditions Hypertension, Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2 W. Mulberry St Date signed 8/31/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66406
AB-15911

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66406

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Ashburton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Leser-or Frederick Lesser

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1-1-1873
8. AGE: Years 75 | Months | Days | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ? Martin Lesser
13. Birthplace ? Russia

MOTHER
14. Maiden Name Annie Maiser
15. Birthplace ? Russia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1/48. (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway A.A.Co.Md.

18 (a) Funeral director Harry A. Tuttle
(b) Address 4101 Edmondson Ave.

19 (a) (Date received by local Registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 11.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17- 1918, to 8-28- 1948, and that I last saw him alive on 8-28- 1948.

Immediate cause of death: Respiratory failure, Cerebral thrombosis — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Rt. pulmonary congestion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Beckbold, M.D.
Address Balto City Hosp. Date signed 8-30-48

VS 150

66407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9-37

Registered No. 666407

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution:
Good Samaritan Nursing Home 18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Good Samaritan Nursing Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George WILLIAM SCHIMINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1889

8. AGE: Years 58 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Davis Coal & Coke Co.

FATHER
12. Name George C. Schiminger
13. Birthplace Md.

MOTHER
14. Maiden Name Emma B. Mainz
15. Birthplace Md.

16 (a) Informant Mrs. Emma Graham
(b) Address 3712 Cranston Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2/48 (month)
(c) Cemetery or crematory Baltimore
Location North Ave. & Gay St.

18 (a) Funeral director Harry A. Winkler
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948 at 5 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertension C.J. Pneum

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature M.D.
Medical Examiner

Date signed 8-31-48

Huntington Woods, Mich.

Registrar

VS 15t

X

66408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G66408

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 W Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 723 E Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Coyle

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widowed

6 (b) Name of husband or wife William Coyle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1877

8. AGE: Years 71 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Carr
13. Birthplace

MOTHER
14. Maiden Name Catharine
15 Birthplace

16 (a) Informant Sarah Harvey
(b) Address 406 E Biddle St

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Cathedral
Location Baltimore

18 (a) Funeral director Milligan Cook Inc
(b) Address 1917 St Paul St

19 SEP 1 1948 (Huntington Williams, M.D.)
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1948 at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1948 to Aug 30 1948, and that I last saw he alive on Aug 28 1948.

Immediate cause of death. Acute Cardiac Failure — Duration 2 hrs.

Due to Hypertension — 3 yrs.

Due to

Other Conditions Myocarditis — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Thompson M. D.
Address 723 N Patterson Pk Date signed Aug 31, 1948

VS 150

G6409 / 131a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66409

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Berlona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. 7107 Windsor Mill Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CORDELIA L. HILDEBRANDT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: Frank M. Hildebrandt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3rd 1859

8. AGE: Years	Months	Days	If less than one day
89	7	27	hr. min.

9. Birthplace Howard Co. Maryland. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Andrew Timanus
13. Birthplace Baltimore Co Md.

MOTHER
14. Maiden Name
15. Birthplace Maryland.

16 (a) Informant F. M. Hildebrandt
(b) Address 198 Oakdale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1st 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location 3801 Frederick Ave.

18 (a) Funeral director Phillips Funeral Home
(b) Address 4810 Liberty Heights Ave.

19 SEP 1 1948 (Date rec'd by registrar) (b) Huntington Ave Registrar, M.D.

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Aug. 30th 1948, at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1948 to Aug 30 1948 and that I last saw her alive on Aug 30 1948

Immediate cause of death — Duration

Chronic Myocarditis — many

Due to

Due to

Other Conditions Contributory Syphilis Aortic & Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Johnson M.D.
Address 112 W. Saratoga St. Date signed Aug 30. 48

93D

VS 150

IS-66410
Bal 138078

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 209

Registered No. 66410

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 34yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Shakespear Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Keuhne

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 17- 1894

8. AGE: Years	Months	Days	If less than one day
53	11	26	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Edward Keuhne
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary McKenna
15. Birthplace Ireland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Germantown Rd

18 (a) Funeral director Edw. J. Gahagan Sons
(b) Address 318 W. Fay. St.

19 (a) SEP 1 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12- 1948; at 10.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10- 1948 to 8-12 1948, and that I last saw him alive on 8-12- 1948

Immediate cause of death Pulmonary tuberculosis — Duration ?

Due to

Due to

Other Conditions Positive Serological test for Syphilis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulm. T.B. & Cavitation-bilat.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul A. Burda M. D.
Address Baltimore City Hosp Date signed 8/21/48

12/12

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

✓ G66411 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5019 Orville Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Morris ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-31-37

8. AGE: Years 10 | Months 0 | Days - | If less than one day hr. min.

9. Birthplace Va (Town, county and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Robert L. Morris
13. Birthplace Va

MOTHER 14. Maiden Name Frances Robinson
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 1/48 (month) (day) (year)
(c) Cemetery or crematory Roanoke Va
Location same

18 (a) Funeral director Udell Funeral Home
(b) Address 2008 Orleans St

19 (a) SEP 1 1948 (Date rec'd by registrar) (Funeral director) Huntington Williams M.D.

VS 150

To approve Interment Medical Examiner

MEDICAL CERTIFICATION

35

20. DATE OF DEATH Aug 31 1948 at 9:2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30-19 48 to 8-31-19 48 and that I last saw him alive on 8-31 19 48

Immediate cause of death: Anaphylactic Reaction - (Horse Serum) — Duration:
Due to Hypersensitivity to FOREIGN PROTEIN
Due to
Other Conditions Tetanus - Complication of Compound FRACTURE - Rt. FOREARM
(Include pregnancy within 3 months of death)

Date of operation Aug 12, 1948 Aug 30 1948
Major findings of operation: (1) Compound fracture Rt. Forearm (2) Postoperative infection
of autopsy:

PHYSICIAN: Underline the one which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence August 12 at 6 PM M
(c) Where did injury occur? 5019 Orville Ave. (City or town) Balto. (County) MD (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? —
(e) Means of injury Fell from tree

23. Signature John William Hellman M. D.
Address JOHNS HOPKINS HOSPITAL Date signed Sept 1, 1948

5412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66412

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs 6 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE FELMER BOWMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-20-5602

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife Lottie M. Bowman
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr) Feb 15 1888

8. AGE: Years	Months	Days	If less than one day
60	6	12	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Pharmacist
11. Industry or business Maryland

FATHER
12. Name George Bowman
13. Birthplace Date Md

MOTHER
14. Maiden Name Ella Monmouth
15. Birthplace Boydton Va

16 (a) Informant Son
(b) Address 8618 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2. 1948 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Md

18 (a) Funeral director Wm. Wm. Wm. Tucker & Son
(b) Address 5311 Edmondson Ave

19 SEP 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 30, 1948 at 12 32 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29- 1948, to 8-30 1948, and that I last saw h I M alive on 8-30 1948.

Immediate cause of death Acute Pulmonary Edema and Right Cardiac Vascular Accident.

Duration

Due to Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary Edema Left ventricular hypertrophy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature George P. Grove M.D.
Address Union Memorial Hospital Date signed 8/30/48

VS 150

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

66413

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 82a

Registered No. 66413

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1516 N. Gilmore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 N. Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA VENNY HUGHLETT

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Separated

6 (b) Name of husband or wife Clifton Hughlett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1894

8. AGE: Years	Months	Days	If less than one day
53	11	29 27	hr. min.

9. Birthplace Westmoreland, Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Nelson Smith
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Virginia

16 (a) Informant Frank R. Venny-Son
(b) Address 430 N. 23rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Arbutus, Md.
18 (a) Funeral director Charles [illegible]
(b) Address 802 Madison Ave.
19 (a) SEP 1 1948 (Date rec'd by Registrar) (b) Courtney Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1948, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 1948, to 8-29 1948, and that I last saw her alive on 8-29 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Coronary Thrombosis	
Due to Arteriosclerosis	
Other Conditions Gastro Enteritis Probable	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)
(e) Means of injury
23. Signature [illegible] M. D.
Address 612 Edmondson Ave. Date signed

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

5814

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

Registered No. 666414

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1723 Westwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Westwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA BELL HALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Charles Hall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1881

8. AGE: Years	Months	Days	If less than one day
67	3	26	hr. min.

9. Birthplace King George County, Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isiah Wilkins
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Wilkins
15. Birthplace Virginia

16 (a) Informant Charles Hall
(b) Address 1723 Westwood Avenue

17 (a) Burial (b) Date thereof 9-2-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles F. Law
(b) Address 802 Madison Ave
(b) Huntington Williams M.D.
(Registrar)

SEP 1 1948
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1948 at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1948 to 8/30 1948 and that I last saw her alive on 8/26 1948.

Immediate cause of death Carcinoma of Breast
Due to C Generalized metastasis.

Duration 3 y 2 m 3 d.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature J. Preston Grant
Address 601 N. Carroll Ave Date signed 8/31/48 M.D.

VS 150

G66415

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46 B

Registered No. G66415

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 159 days
(e) Length of stay in Baltimore (yrs., mos., or days): 159 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: NY (b) County: New York
(c) City or town: (If outside city or town limits, write RURAL and give town)
(d) Street No.: 105 Broad St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: OWEN TULLER ROWE

3 (b) If veteran, name war: ?
3 (c) Social Security Account No.: ?

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 4, 1893

8. AGE: Years: 55 | Months: 2 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Columbus, Ohio (Town, county, and state)
10. Usual Occupation: Carpenter
11. Industry or business: Seafarer

FATHER
12. Name: Grant Rowe
13. Birthplace: ?

MOTHER
14. Maiden Name: Olive Tuller
15 Birthplace: Columbus, Ohio

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 1-48 (month) (day) (year)
(c) Cemetery or crematory: Evergreen Cem. Baltimore County
Location: York Road
Lutherville Md.

18 (a) Funeral director: Huntington Williams
(b) Address: 403 E. 25th St.

19 SEP 1 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 23 1948 to Aug. 29 1948, and that I last saw h im alive on Aug. 29 1948.

	Duration
Immediate cause of death: 1- Peritonitis of unknown etiology with intestinal obstruction, partial	Several mos.
~~Due to~~: 2- ~~Gastric ulcer~~ Adenocarcinoma of stomach	6 mos.
Due to: ulceration or ulcer,	
~~Other Conditions~~: chronic, gastric & carcinoma	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 8/30/48

VS 150

66416 BC-C 99324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 66 B

Registered No. 66416

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8hrs. 35min.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 mo. 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Ellerslie Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME VIRGINIA LEE BOESCHE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 23, 1947

8. AGE: Years	Months	Days	If less than one day
—	8	8	— hr. — min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name CHARLES ROBERT BOESCHE
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name LOLA BRUGGMAN
15 Birthplace Churchville, Md.

16 (a) Informant Parents Charles R. Boesche
(b) Address 3014 Ellerslie Ave, Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/48 (month) (day) (year)
(c) Cemetery or crematory London Park Cemetery
Location Frederick Ave

18 (a) Funeral director Howard H. Blight Jr.
(b) Address 6209 Harford Road

SEP 7 1948 (Date rec'd by registrar) (b) Interment or Cremation, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1948 at 4 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31, 1948 to Aug. 31, 1948, and that I last saw h[illegible] alive on Aug. 31, 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	?
Due to hypocalcemia	
Due to —	
Other Conditions Jaundice of unknown eiology. (Include pregnancy within 3 months of death)	9 days
Date of operation —	
Major findings of operation: —	
of autopsy: None	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Union Memorial Hosp. Date signed Aug 31, 48

VS 183

X

66417

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. 66417

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division ST
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1061 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No. Unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	married

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/11/86

8. AGE: Years	Months	Days	If less than one day
62	7	18	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mr Nelson Dare
13. Birthplace Md

MOTHER
14. Maiden Name Miss Evelyn Cates
15. Birthplace Md

16 (a) Informant Daughter
(b) Address 900 Mod ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location W. Halstead

18 (a) Funeral director W. Druid Hill Ave.
(b) Address 948

19 SEP 1 1948 (Date rec'd by Registrar) (b) Huntington Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1948, at 1050PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1948, to 8/28 1948, and that I last saw her alive on 8/28 1948.

Immediate cause of death Cerebral vascular accident with Right + Left Heart failure — Duration

Due to Heart failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature St Elmo Brady M. D.
Address 1514 Division ST Date signed 8/29/48

St Elmo Brady.

VS 150

66418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G66418

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 14-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Brunt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 40 | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant:
(b) Address

17 (a) Burial, cremation, or removal (b) Date [illegible] 1908
(c) Cemetery or crematory
Location

18 (a) Funeral director G. Harold Hill
(b) Address

19 (a) SEP 1 1908 (b) Huntington Woodlawn, Md.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Aug 1908, at 4 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Myocardial Degeneration

Other Conditions Fatty Degeneration? Liver.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royster M.D.
Medical Examiner.
Date signed 28 Aug 08

VS 151

correct age is especially important. Physicians, please write the cause of death plainly and legibly.

666419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 B

666419 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Brentwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISLAM DAVIS Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Grace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1906

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Islam David Sr.
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace Va.

16 (a) Informant Grace Davis
(b) Address 1702 Brentwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director W. Halstead
(b) Address 918 Druid Hill

1948 SEP 1 (Date rec'd by registrar) Huntington Williams, Inc.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 1948, at 9.20a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death.)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 8-26-48

VS 151

66420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G66420 14742
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1218 E Monument St.
(c) Hospital or institution: -
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No),
If yes, name country

3 (a) FULL NAME Nannie O'Brien

3 (b) If veteran, name war —

3 (c) Social Security Account No. -

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Freddie

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr) 1894

8. AGE: Years 54 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Peter Banks
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rosie
15 Birthplace Baltimore

16 (a) Informant Freddie O'Brien
(b) Address 1218 E Monument St.

17 (a) Burial (b) Date thereof 9-1-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Catonsville, Md.

18 (a) Funeral director A. Leland Hill
(b) Address 918 Druid Hill Ave

SEP 1 1948
(Date rec'd by registrar)

(b) Interment or Removal

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1948, at 9:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1948, to Aug 27 1948, and that I last saw her alive on Aug 27 1948.

Immediate cause of death Lobar Pneumonia — Duration 10 days

Due to

Due to

Other Conditions Cirrosis of Liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ronald Bliss Jr. M. D.
Address 501 Cherry Hill Rd Date signed 8-27-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. 166421

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1544 N Bulso St

(c) Hospital or institution:

Provident Hospital 14-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore Md

(If outside city or town limits, write RURAL and give town)

(d) Street No. 521 N Bund St

(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Nathan Waters

3 (b) If veteran, name war	3 (c) Social Security Account No.
unknown	unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Separated

6 (b) Name of husband or wife unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/25/1896

8. AGE: Years	Months	Days	If less than one day
48	9	4	hr. min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name Mr John Waters

13. Birthplace unknown

MOTHER

14. Maiden Name Mrs Mary ?

15. Birthplace unknown

16 (a) Informant Deceased

(b) Address 521 N Bund St

17 (a) Burial (b) Date thereof 9-2-48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Halsted & Druid Hill Ave

18 (a) Funeral director A. Hall

(b) Address 918- Druid Hill Ave

DEC 1 1948

(Date rec'd by registrar)

Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29/48 1948, at 11.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1948 to 8/29 1948 and that I last saw h[illegible] Malive on 8/29 1948

Immediate cause of death Cirrhosis of Liver

Due to Excessive drinking of Alcohol

Due to

Other Conditions Pulmonary Congestion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature St Elmo Brady M.D.

Address 514 Dunbar St Date signed 8/30/48

St Elmo Brady

X

3822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66422

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Grant & Saratoga
(c) Hospital or institution: Mary Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city limits, write RURAL and give town)
(d) Street No. 5 [illegible] Bentwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Jackson

3 (b) If veteran, name war 0

3 (c) Social Security Account No. 216-05-1748

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mary Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 10, 1894

8. AGE: Years	Months	Days	If less than one day
53	10	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Business manager
11. Industry or business Continental Can Co.

FATHER
12. Name George Jackson
13. Birthplace

MOTHER
14. Maiden Name Ann C Weller
15. Birthplace Baltimore, Md

16 (a) Informant Mary Jackson
(b) Address 5313 (5316) Bentwood Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Road 14

19 SEP 1 1948 (Date rec'd by registrar) (b) Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31 1948 at 11:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1948 to 8-31 1948 and that I last saw h/ alive on 8-31 1948

Immediate cause of death Acute pulmonary edema — Duration
Due to myocardial failure
Due to Coronary Occlusion
Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death) Mild

Date of operation
Major findings of operation:
of autopsy: Myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence / at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bond Duvall, Jr. M. D.
Address Mary Hosp. Date signed 8-31-48

VS 150

X

JOHN F. QUINN

66423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

Registered No. 66423

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4201 Falls Road (If rural, give location) W. 17
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Quinn

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-10-1627

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ruth F. Quinn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 12-1890

8. AGE: Years 57 | Months 9 | Days 18 | If less than one day: hr. min

9. Birthplace Lowell, Mass. (town, county, and state)

10. Usual Occupation Razer

11. Industry or business Miller Bros.

FATHER
12. Name Ethelbert Quinn
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Brady
15. Birthplace Mass.

16 (a) Informant Mrs. Ruth F. Quinn
(b) Address 4201 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2-1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 4631 Falls Road

19 SEP 1 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1948 at 1:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 21 1948 to Aug 30 1948 and that I last saw him alive on Aug 30 1948.

Immediate cause of death Congestive failure — Duration

Due to Arteriosclerotic Heart disease — Duration

Due to CA pulmonale Auricular pulmonary fibrosis — Duration

Other Conditions Bronchial asthma — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John White M. D.
Address Univ. Hosp. Date signed 8-30-48

Correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS 150

666424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 1a

666424 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 1333 Weldon Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1333 Weldon Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Newton Meyls

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Laura E. Meyls
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 22, 1873

8. AGE:

Years	Months	Days	If less than one day
75	7	7	hr. min.

9. Birthplace Carroll Co., Maryland (Town, county, and state)
10. Usual Occupation Car Inspector
11. Industry or business Pa. Railroad

FATHER
12. Name Lewis O. Meyls
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Houck
15. Birthplace Maryland

16 (a) Informant Mrs. Laura E. Meyls
(b) Address 1333 Weldon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Sept 1 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH August 29, 1948 at 4.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1948 to Aug 29 1948 and that I last saw h alive on 27 Aug 1948

Immediate cause of death	Duration
Left Ventricular failure	1/2 hr.
Pulmonary oedema	1/2 hr.
Due to Bright's Disease	2 days
Due to Heart.	

Other Conditions Cardiac vascular renal disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Feldstein, M.D.
Address 744 E. Preston Date signed Sept 1 1948

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

666425

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 666425

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1626 Morland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1626 Morland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Pearce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 68 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business

FATHER 12. Name: Michael J Bloom
13. Birthplace: Poland

MOTHER 14. Maiden Name: Katz
15. Birthplace: Poland

16 (a) Informant: Lew Pearce
(b) Address: 1608 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-1-48 (month) (day) (year)
(c) Cemetery or crematory: Helen Friendship
Location: E. Balt St

18 (a) Funeral director: Jack Levin Inc
(b) Address: 2100 Eutaw Pl

19 (a) SEP 1 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-31-1948 at 6 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1947 to Aug. 31, 1948, and that I last saw h[illegible] alive on Aug 31, 48

Immediate cause of death: Acute Cardiac failure — Duration
Due to: Myocardial Insufficiency
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: M D Neale
Address: 2424 N Monroe St Date signed: 9/1/48

VS 150

Correct age is especially important. Physicians, please write the name of death clearly and legibly.

66426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 666426

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 Monument St
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Kirkton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Adler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1850

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Benjamin
13. Birthplace Russia

MOTHER
14. Maiden Name Ada
15. Birthplace Russia

16 (a) Informant Ada Adler
(b) Address 2003 Kirkton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Lewis Inc
(b) Address 2400 Eutaw Place

19 (a) 9/1/48 (Date rec'd by registrar) (b) [illegible] for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1948, at 8:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 8/20 1948 to 8/31 1948, and that I last saw him alive on 8/31 1948.

Immediate cause of death Pulmonary Edema — Duration

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions Diabetes Mellitus
Broncho Pneumonia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard Epstein M.D.
Address Sinai Hospital Date signed 8/31/48

I certify that the above is a true and correct statement of the facts relating to the cause of death. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

VS 150

92

66427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 66427

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 Mosher St
(c) Hospital or institution: —
14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Fallins Gilmore

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race Negro

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Cyrus Gilmore

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — — 1855

8. AGE: Years 93 | Months ? | Days ? | If less than one day — hr. — min.

9. Birthplace Lancaster Co. Va (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John Fallins
13. Birthplace Lancaster Co, Va

MOTHER
14. Maiden Name Mary —
15. Birthplace Lancaster Co. Va

16 (a) Informant Mrs Eleanor Lindsey
(b) Address 519 Mosher St

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto city - Md

18 (a) Funeral director Holland Funeral Home
(b) Address 1631 Mund Hill Ave

19 SEP 1 1948 (Date rec'd by registrar) Huntington Williams Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 August 1948, at 9 3/4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to 8-29-1948, and that I last saw h er alive on 8-29-1948.

Immediate cause of death
pulmonary edema
Duration 1 hour

Due to cardiac decompensation, acute
Duration 2 hours

Due to arteriosclerotic cardiovascular disease
Duration 3 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James D. Carr, M. D.
Address 515 Mosher St Date signed 9-1-48

correct age is especially important. Physicians: please write the cause of death very plainly.

66428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 66428

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1022 N. Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 N. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Millie Bond

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife Johnie Bond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 19, 1875

8. AGE: Years	Months	Days	If less than one day
72	10	10	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER — 12. Name Dennis Johnson
13. Birthplace Va

MOTHER — 14. Maiden Name Matilda Lewis
15. Birthplace Va

16 (a) Informant Laura Jones
(b) Address 1215 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George G. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) SEP 1 1948 (Date rec'd by registrar) (b) Huntington, W. Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH aug 29 1948, at 4.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25 1948 to 8-29 1948 and that I last saw her alive on 8-29 1948

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 612 Edmondson Ave Date signed

Please write plainly, with pen or pencil, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 666429

OF DEATH:
nore City, Maryland
address 2001 Penna. Ave
tal or institution:

h of stay in hospital or inst. (yrs., mos., or days) 14 - 3
h of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Penna. Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

L NAME Georgianna Danby

eteran, name war —

(c) Social Security Account No. —

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. W

me of husband or wife John Danby

6 (c) If alive, give age years

late of deceased (mo., day, yr.) 1858

Years	Months	Days	If less than one day
90			hr. min.

lace Baltimore, Md. (Town, county, and State)

l Occupation Housewife

stry or business

ame Terry Moore

irthplace Md

Maiden Name Unknown

irthplace Unknown

nformant Ezra Young

ddress 2001 Penna. Ave

Buried (b) Date thereof 9-2-48 (month) (day) (year)
urial, cremation, or removal

Cemetery or crematory Mt Auburn

Location Md

Funeral director George D. Wilson

Address 1003 Pennsylvania Ave

9-1 1948 (b) Washington Nilliams, Md.
ate received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30- 1948 at 10:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26- 1948 to 8-30- 1948 and that I last saw h alive on 8-30- 1948

Immediate cause of death: Heat Exhaustion — Duration 3 days

Due to

Due to

Other conditions Chronic Valvular Heart — 6 mos
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Bage, M.D.
Address 1616 N. Monroe St Date signed 9-1-48

191

66430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 666450

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 Cumberland St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 627 Cumberland St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth Wise

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife John E. Wise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1877

8. AGE: Years	Months	Days	If less than one day
70	8	13	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Louise Dip
13. Birthplace Va

MOTHER
14. Maiden Name Margaret Beef
15. Birthplace Va

16 (a) Informant Annie Watt
(b) Address 627 Cumberland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George F. Nelson
(b) Address 1303 Pennsylvania St

19 (a) SEP 1 1948 (Date rec'd by registrar) (b) —

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1948, at 2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1948, to Aug 28 1948, and that I last saw her alive on Aug 27 1948

Immediate cause of death: Arteriosclerotic Heart Disease — Duration ?

Due to

Due to

Other Conditions Endangering constipation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Carnes

Address 753 George St Date signed 8/29/48

VS 150

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

8431 Dr. Post
6805 York Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97

G66431
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2632 Kirk Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2632 Kirk Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Lee Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Jacob H. Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 4. 1873

8. AGE: Years	Months	Days	If less than one day
75	-	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George C. Ness
13. Birthplace Md.

MOTHER
14. Maiden Name Hester A. Constantine
15 Birthplace Md.

16 (a) Informant Mrs. Blanche Ashcraft
(b) Address 2632 Kirk Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Date rec'd by Registrar 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29th 1948, at 9.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1948 to Aug 29 1948, and that I last saw her alive on Aug 21 1948.

Immediate cause of death Acute Cardiac Failure — Duration

Due to Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify) (Specify)
(e) Means of injury

23. Signature Laurence C. Fisk M.D.
Address 605 York Rd. Date signed 8/31/48
M D

VS 150

G. L. Merrill MD

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66432
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1308 S. Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Pheasant Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Zelenka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife James Zelenka

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22 1866

8. AGE: Years 82 | Months 1 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Bohemia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Sott
13. Birthplace Bohemia

MOTHER
14. Maiden Name Elizabeth —
15. Birthplace Bohemia

16. (a) Informant Cathy Zelenka
(b) Address Govans Md

17. (a) Burial (Burial, cremation or removal) (b) Date thereof 9-2-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18. (a) Funeral director Frank Bupack Sons
(b) Address 900 N Chester St

19. (a) Date received by registrar SEP 1 19[illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1948 [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1948 to Aug 30 1948 and that I last saw h[illegible] alive on Aug 30 1948.

Immediate cause of death BRONCHIAL PNEUMONIA — Duration 2 DAYS

Due to

Due to

Other Conditions DIABETES MELLITUS 20 yrs??
(include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph F Krenzer M. D.
Address 209 S. Chester St Date signed 8/31/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

107

G66433 Harvey

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G66433

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 411 N. Madeira St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 411 N. Madeira St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Bednar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Barbara Bednar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 2, 1868

8. AGE: Years	Months	Days	If less than one day
80	1	26	hr. min.

9. Birthplace Laborer (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Bednar

13 Birthplace Bohemia

MOTHER 14. Maiden Name not known

15 Birthplace Bohemia

16 (a) Informant Barbara Bednar

(b) Address 418 N. Madeira St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balt Md

18 (a) Funeral director Frazier Brockden

(b) Address 900 N. Chestnut

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

SEP 1 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31, 1948, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1948 to 8/31 1948 and that I last saw him alive on 8/30 1948.

Immediate cause of death Coronary Occlusion — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph Pokorny

Address 2200 E Madison Date signed 8/31/48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

Registered No. G66434

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ... 323
(c) Hospital or institution: South Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) ...
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County ...
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 E OSTEND ST.
(If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country ...

3 (a) FULL NAME CHARLES STEPHAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-09-9671

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife ADELE STEPHAN

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) JULY 25-189

8. AGE: Years 57 | Months 1 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation PRESSMAN

11. Industry or business U.S. LITHOGRAPHING Co

FATHER
12. Name HARRY. F. STEPHAN
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name CATHERINE PEGLOW
15. Birthplace MARYLAND

16 (a) Informant ADELE STEPHAN
(b) Address 27 E OSTEND ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-4-48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK ROAD

18 (a) Funeral director Bernard C Hasle
(b) Address 121 E West St

(Date rec'd by registrar) 1 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1948, at 11 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1948, to 8/31 1948, and that I last saw him alive on 8/31 1948.

	Duration
Immediate cause of death: Ruptured cardiac aneurysm	?
Due to: Myocardial infarction	5 days
Due to: Coronary occlusion	5 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation ...
Major findings of operation: ...
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ...
(Specify type of place)
(e) Means of injury ...

23. Signature Glenn O. Summerlin
Address 1213 Light St. Date signed 9/1/48 (M) (D)

VS 150

G66435

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 462

G66435
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Cedardale Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNIE ELIZABETH McCORMICK

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Charles E. McCormick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 3, 1885

8. AGE: Years 63 | Months 5 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Utermohle
13. Birthplace Balto.

MOTHER
14. Maiden Name Margaret J. Leisher
15. Birthplace Md.

16 (a) Informant Mr. Charles E. McCormick
(b) Address 3402 Cedardale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (c) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Rec'd by reg. (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31 1948, at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1948, to 8-31 1948, and that I last saw h alive on 8-31 1948.

Immediate cause of death
Respiratory Failure and Cachexia
Due to Ca Head Pancreas.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Ca Head Pancreas - Metast. Liver

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify type of place)
(e) Means of injury
23. Signature Richard C. Haythe M. D.
Address Bon Secours Hosp. Date signed 8-31-48

VS 150

G66436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G66436

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1204 Bentalou St
(c) Hospital or institution: 16-
(d) Length of stay in hospital or inst. (yrs., mos., or days) one
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 N Bentalou St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter H. Melvin

3 (b) If veteran, name war Spanish Am. | 3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3 - 1879

8. AGE: Years	Months	Days	If less than one day
69	5	29	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Dancing Instructor
11. Industry or business

FATHER
12. Name John H. Melvin
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Isabella Tolley
15. Birthplace Baltimore Md

16 (a) Informant Miss Marie Elliott
(b) Address 1204 N Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4-48 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location
18 (a) Funeral director Charles P. Towell
(b) Address 2727 Edmondson Ave
19 (a) [illegible] (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1948, at 4:40 M

21. I certify that death occurred on the date above stated, that I attended deceased from July 27 1948, to Sept 1 1948, and that I last saw him alive on August 31 1948.

Immediate cause of death Chronic Interstitial Nephritis — Duration 1 month

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Riland, M. D.
Address 2532 Edmondson Ave Date signed 9-1-48.

PLEASE WRITE PLAINLY, with ink or indelible pencil. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1s

G66437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1141

G66437 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hosp. 21+
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Woodward St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry A Reynolds Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14th 1906

8. AGE: Years 42 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Henry A. Reynolds
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Ella M. Wegworth
15. Birthplace Baltimore Md

16 (a) Informant Mrs Ella M. Reynolds
(b) Address 813 Woodward St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/48 (month, day, year)
(c) Cemetery or crematory London Park Cem.
Location 3801 Frederick Ave

18 (a) Funeral director John J. Govan & Son
(b) Address 901-03 Hollins St

19 (a) Date received (by registrar) (b) Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1948 at 3:30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cancer of Lung

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature George F. Pickett M.D.
Medical Examiner.
Date signed 9-3-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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G66438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48

G66438

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 N. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Crenshaw

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 1882

8. AGE: Years 66 | Months 3 | Days | If less than one day: hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER 12. Name Preston Crenshaw
13. Birthplace Va

MOTHER 14. Maiden Name Sally Miller
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Remove (Burial, cremation, or removal) (b) Date thereof Sept 2/48 (month) (day) (year)
(c) Cemetery or crematory Crave Va
Location .....

18 (a) Funeral director McCatt & Elliott Dingle
(b) Address 1129 N. Carlin St

19 (a) Date received by registrar (b) Registrar

VS 189

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20

20. DATE OF DEATH Aug 31 1948, at 11 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1948 to Aug 31 1948 and that I last saw h[illegible] alive on 8-31-1948

Immediate cause of death: Pulmonary Embolism, bilateral — Duration: 14 mos

Due to: Sarcoma Uterus with Metastases to Lungs, Liver, Inguinal Lymph Nodes

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation 8-20-48

Major findings of operation: Huge (30#) Tumor, Sarcoma of Uterus

of autopsy: See Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Kinard Hanson, M.D.
M. D.

Address JOHNS HOPKINS HOSPITAL Date signed 8-31-48

G66439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G66439
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 Dallas Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: BERTHA WORTHAM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	6 (b) Name of husband or wife	6 (c) If alive, give age
Female	Colored	married	Harry	years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years	Months	Days	If less than one day
30			hr. min.

9. Birthplace Warrenton N.C. (Town, county, and state)

10. Usual Occupation (House Wife)
11. Industry or business

FATHER 12. Name	Mr. Aefud Kerney
FATHER 13. Birthplace	N.C.
MOTHER 14. Maiden name	Mrs. Rosie Kerney
MOTHER 15. Birthplace	NC

16 (a) Informant Mr Harry Wortham
(b) Address 282 Dallis Ct.

17 (a) [illegible] (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Warrenton N.C.
Location
17 (a) Funeral director Mrs. N. A. E. Pitts Daughter
(b) Address 1419 N. Caroline St.

19 (a) [illegible] Date received by registrar Tennington Williams, registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1948, at 1:15 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-31-48 at 12:45 A M.?
(b) Where did injury occur? 1418 Orleans St.
(c) Did injury occur at home, on farm, industrial place, in public place? Restaurant While at work? No
(d) Means of injury Firearms

23. Signature [signature] M.D.
Medical Examiner.
Date signed 8-31-48

X

G66440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

G66440 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2469 Shirley Ave.
(c) Hospital or institution:
West Baltimore General Hospital DOA 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2469 Shirley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Ballasohn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec, 4, 1889

8. AGE: Years	Months	Days	If less than one day
58	8	27	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Cleaners & Dyers

FATHER
12. Name Abraham Ballasohn
13. Birthplace Russia

MOTHER
14. Maiden Name Anna ?
15. Birthplace Russia

16 (a) Informant Mrs Abe Ballasohn
(b) Address 2576 Druid Park Drive

17 (a) Burial (b) Date thereof Sept. 2/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory North Point Rd Cem
Location German Hill Rd.

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-1126 N. North Ave.

19 (a) (b) Huntington Notarius, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1948, at 9:48a M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from; natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broken neck.
Fracture skull, avulsion of Brain
Intra-cranial hemorrhage.
Due to External hemorrhage

Other Conditions Lacerations, bruises, bruises.
(Include pregnancy within 3 months of death)

22. If an external cause was ~~immediate~~ ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/31/48 at 9:35 A.M. 27-18
(b) Where did injury occur? Belvedere Ave. & Reistertown Rd.
Did injury occur at home, on farm, industrial place, in public place? pulic While at work? no
(d) Means of injury struck by streetcar, (ped.)

23. Signature Howard J. Mallecis M.D.
Medical Examiner.
Date signed 8/31/48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G66442 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital D O A
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 S. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	M

6 (b) Name of husband or wife Elenora Connor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 8, 1881

8. AGE: Years	Months	Days	If less than one day
67	5	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Alfred Hopkins
13. Birthplace Baltimore

MOTHER
14. Maiden Name Virginia Bentz
15. Birthplace Baltimore

16 (a) Informant Elenora Hopkins
(b) Address 9 S. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/48 (month)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) 1948 (Date received by registrar) (b) Filing for Williams Mgr. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 5:50 PM

21. I certify that I took charge of the remains described above, held an inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? What was he doing at work?
(d) Means of injury

23. Signature M.D. (Medical Examiner)
Date signed 30 Aug 48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G66442
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 427 S. Robinson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 427 S. Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elton A. Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maude V. Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 13, 1880

8. AGE: Years	Months	Days	If less than one day
67	9	18	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Carpenter (Retired)
11. Industry or business Carpenter

FATHER
12. Name John W. Hall
13. Birthplace Md.

MOTHER
14. Maiden Name Mary F. Jones
15 Birthplace Md.

16 (a) Informant Mrs. Maude V. Hall (Wife)
(b) Address 427 S. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- 2 -48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) SEP 1948 (Date received by registrar) (b) Washington Irvine Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948, at 10:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1947 to Aug. 30 1948
and that I last saw h[illegible] alive on August 30 1948.

Immediate cause of death — Duration

Myelogenous Leukemia — 2 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clarence W. LeGore M.D.
Address 601 S. Ellwood Ave Date signed 9/3/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G66443

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 802 N. Port Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 802 N. Port Street
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Frank Drsata

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ida Ludwig Drsata

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1887

8. AGE: Years	Months	Days	If less than one day
61	3	15	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual Occupation retired tailor

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Ida Ludwig Drsata - wife

(b) Address 802 N. Port Street

17 (a) Burial (b) Date thereof 9/2/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Hill

Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.

(b) Address 2601-3-5 E. Madison Street

19 (a) (Date received) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30- 1948 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27- 1948 to 8-30 1948.

and that I last saw h[illegible] alive on 8-30- 1948.

Immediate cause of death	Duration
Pneumonia	1 Day
Due to	
Due to	
Other Conditions Parkinson's disease	20 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 8-31-48

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G66444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G66444
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2420 Ashland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 Ashland Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Kostek

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ John Kostek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1881

8. AGE: Years	Months	Days	If less than one day
67	5	11	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Sako
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Theresa Ballay
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Helen Picek - daughter
(b) Address 2420 Ashland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) Date received 1948 (b) Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1948 at 7 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1948 to 8/30 1948, and that I last saw h alive on 8/29 1948.

Immediate cause of death	Duration
heart insufficiency	4 days.
Due to	
Due to	
Other Conditions acute myocardial infarction (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L C Schlicht M. D.
Address 447 N. Kenwood Ave. Date signed 9/2/48

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G66445

BALTIMORE CITY HEALTH DEPARTMENT ✓ G66445
Registered No.

CERTIFICATE OF DEATH 47c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2825 O Donnell st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2825 O Donnell st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anthony Kuchta

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 10 1906

8. AGE: Years	Months	Days	If less than one day
42	1	21	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Ships Builder
11. Industry or business Md. Dry Docks

FATHER
12. Name John Kuchta
13. Birthplace Poland

MOTHER
14. Maiden Name Agusta Ketcel
15. Birthplace Poland

16 (a) Informant Miss Eva Kuchta
(b) Address 2825 O Donnell st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3 1948 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem.
Location Dundalk Ave

18 (a) Funeral director Marie E. Stalkowski
(b) Address 1000 S. Kenwood Ave

19 (a) (Date received by registrar) (Signature of Registrar) Williams, M.D. Registrar

SEP 1
VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Aug. 31 1948 at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 20 July 1948 to 31 Aug. 1948, and that I last saw him alive on 31 Aug. 1948

Immediate cause of death	Duration
Respiratory failure	1 hr.
Due to Carcinomatosis, Pleural effusion	3 mos.
Due to Bronchogenic carcinoma of lung	6 mos.
Other Conditions Cachexia, Anaemia	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town), (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Drozd M. D.
Address 2601 Eastern Ave Date signed Sept. 1 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this certificate should be answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G66446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832

G66446

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22nd + Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore - 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 Keating ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Miss Mary Lindsay

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3/10/1882

8. AGE: Years	Months	Days	If less than one day
66	6	20	— hr. — min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Mr. John Lindsey
13. Birthplace West Virginia

MOTHER
14. Maiden Name Augusta Dering
15 Birthplace West Virginia

16 (a) Informant Patients Adm. Record
(b) Address —

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Sept. 2/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Memorial
Location Washington Blvd.

18 (a) Funeral director Easton Sons
(b) Address 608 Frederick Ave Catons

19 (a) 1948 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

EP

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1948, at 8 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1948 to Aug 30 1948, and that I last saw her alive on aug 30 1948.

Immediate cause of death: Cerebral vascular accident — Duration: 16 days
Due to —
Due to —
Other Conditions: hypostatic Pneumonia
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

Signature W. T. Carr M.D.
Address Union Memorial Hosp. Date signed 8-30-48

X

G66447

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66447 83a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 325 N. Calhoun St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Annie L. Thomas

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4 Sex: female
5 Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Robert A.
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 15, 1873
8. AGE: Years 75 | Months 4 | Days 15 | If less than one day: hr. ..... min.
9. Birthplace Royal Oak, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Moses Roberts
13. Birthplace Unknown

MOTHER
14. Maiden Name Caroline Smith
15. Birthplace Royal Oak Md

16 (a) Informant Mrs. Esther Leath
(b) Address 325 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Talbot Co. Md
Location Trinity Lot

18 (a) Funeral director Mrs. Gus A. Holland
(b) Address 1631 Druid Hill Ave

19 SEP 1 1948 (Date rec'd by registrar) (b) Huntingtown Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1948 at 1130 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1948 to Aug 30 1948 and that I last saw her alive on Aug 29 1948.

Immediate cause of death Cerebral hemorrhage — Duration 3 days
Due to Cerebral Arteriosclerosis — Duration unk
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: .....
Date of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature George W. McDonald M. D.
Address 644 N. Carey Date signed 9/1/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 1-50

G66448

JL - 122578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G66448

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Mt. Royal Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Conrad F. Schulz

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-4186

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Emma Schulz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 1, 1879

8. AGE: Years	Months	Days	If less than one day
69	7	30	hr. min.

9. Birthplace Md. (Balto.) (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (c) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/48 (month) (day) (year)
(c) Cemetery or crematory Balto Md.
Location

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 SEP 2 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31, 1948, at 11.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 1948 to Aug. 31 1948, and that I last saw h in alive on Aug. 31 1948.

Immediate cause of death: Sub-arachnoid hemorrhage. arachnoid

Due to Hypertensive Cardiovascular Disease.

Due to

Other Conditions Generalized arteriosclerosis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Absolute

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wellington H. Venters M. D.
Address Balt City Hosp Date signed Sep 48

Please write clearly and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 153

G66449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G66449

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5305 Wright Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Virginia B. Adler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Adolph E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25th 1863

8. AGE: Years 84 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Martin Rudolph
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Woods
15. Birthplace Balto. Md.

16 (a) Informant William Rudolph
(b) Address 1253 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) SEP 2 - 1948 (Date rec'd by registrar) Huntington for Williams Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1948 at 1:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 28 1948 to Sept 1 1948 and that I last saw h[illegible] alive on Sept 1 1948

Immediate cause of death: Arterio-sclerotic Heart Disease — Duration

Due to

Due to Generalized Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence a: M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ray C. Parsons, Jr. M. D.
Address St. Joseph's Hospital Date signed 9/1/48

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS 150

666150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 666150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1001 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Archibald H. Dewdney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age 19th years

7. Birth date of deceased (mo., day, yr.) July 6th 1898

8. AGE: Years: 50 | Months: 1 | Days: 12 21 | If less than one day: hr. min.

9. Birthplace: Switzerland (Town, county, and state)

10. Usual Occupation: Vice Pres.

11. Industry or business: (C) Thermium (C) Inc.

FATHER 12. Name: Harry Lovell Dewdney

13. Birthplace: England

MOTHER 14. Maiden Name: Fanny (Accommazzi)

15. Birthplace: Switzerland Bucommazzi

16 (a) Informant: Martha Dewdney

(b) Address: 95 Lexington Ave. N.Y.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/3/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Woodlawn

Location: N.Y. City N.Y.

18 (a) Funeral director: William Cook Inc.

(b) Address: 1217 St. Paul St.

19 (a) SEP 2 - 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31st 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 24 1943. to Aug 31. 1948. and that I last saw h[illegible] alive on Aug. 31 1948.

Immediate cause of death Pulmonary oedema — Duration: 2 or months

Due to: Coronary occlusion — Duration: 3 one hour

Due to: Arteriosclerosis

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Tilden Howard. M. D.

Address 12 E. Eager St. Date signed Sept. 1, 48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 664451

664451

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 Lyndhurst Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Lyndhurst Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes McKay Barbour

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married
6 (b) Name of husband ~~or wife~~ Alexander R. Barbour
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10th 1875

8. AGE: Years 72 | Months 11 | Days 21 | If less than one day: hr. min.

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name McKay
13. Birthplace Scotland

MOTHER
14. Maiden Name
15 Birthplace

16 (a) Informant Jean Chase
(b) Address 32 Village Green, New Milford, Conn.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Sep 2 1948 (Date received by Registrar) (b) Transit or burial permit issued by Registrar

SEP 2 - 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31st 1948. at 7a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1943. to Aug. 31 1948. and that I last saw h[illegible] alive on Aug. 31 1948.

Immediate cause of death
(a) Cerebral Hemorrhage
Due to Hypertensive Cardio Vascular Disease
Due to
Other Conditions Cerebral Arterio Sclerosis
(Include pregnancy within 3 months of death)

Duration
(a) 2 days
10 yrs.
?

Date of operation None
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 410 E. Liberty St. Date signed 9/1/48.

X

Physicians: please write the causes of death clearly and legibly. Be sure to state correct age in each case. This is especially important.

666452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 666452

BC - 48 - 18826

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light Street.

(c) Hospital or institution: South Baltimore General Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town ..... (If outside city or town limits, write RURAL and give town)

(d) Street No. 1024 Ridgely St. (If rural give location)

(e) Citizen of foreign country? x (Yes or No) If yes, name country .....

3 (a) FULL NAME Infant Boy of Willard & Charlotte Richardson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1948

8. AGE: Years | Months | Days | If less than one day 8 hr. — min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Willard Richardson

FATHER 13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Charlotte Chrzanowski

MOTHER 15. Birthplace Pennsylvania

16 (a) Informant Hospital Record

(b) Address South Baltimore General Hosp.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Sept 2 48 (month) (day) (year)

(c) Cemetery or crematory Glen Haven Cem.

Location Glen Burnie Md.

18 (a) Funeral director Bernard C Hale

(b) Address .....

19 SEP 2 - 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1948 at 12 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 31 1948 to Sept 1 1948 and that I last saw h[illegible] alive on Sept 1 1948.

Immediate cause of death: Atelectasis — Duration 8 hrs

Due to Prematurity

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation ..... Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....

(Specify type of place)

(e) Means of injury .....

23. Signature Charles R Woodward

Address 1213 Light St Date signed 9-1-48

VS 150

G66453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 66353

Bl-48-18827

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 Ridgely St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Infant Boy of Willard & Charlotte Richardson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife [redacted]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31 1948

8. AGE: Years | Months | Days | If less than 1 day: 8 hr. 2 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name Willard Richardson
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Charlotte Chrzanowski
15. Birthplace Pennsylvania

16 (a) Informant Hospital Record
(b) Address South Baltimore Gen. Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2-48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location Glen Burnie Md

18 (a) Funeral director Bernard C. Harlan
(b) Address 121 E. West St.

19 SEP 2 - 1948 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1948, at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 31 1948 to Sept. 1 1948, and that I last saw him alive on Sept. 1, 1948.

Immediate cause of death: Atelectasis — Duration: 8 hrs.

Due to: Prematurity — Duration: 15 min.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R. MacDonald M.D.
Address 1213 Light St. Date signed 9-1-48

VS 150

66454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 2002

Registered No. 666454

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1527 Bolton St.
(c) Hospital or institution: none 14+1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Bolton St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN C. WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1891

8. AGE: Years (56) Months 8 Days 30 If less than one day hr. min.

9. Birthplace Joplin, Mo. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Elijah J. Williams
13. Birthplace ?

MOTHER
14. Maiden Name Alice Virginia Campbell
15. Birthplace ?

16 (a) Informant George J. Tinsley
(b) Address Equitable Trust Co.

17 (a) cremation (Burial, cremation, or removal) (b) Date thereof 9/2/48 (month, day, year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave., Baltimore

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1905 Eutaw Place

19 (a) SEP 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27- 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Impossible to state

Due to Advanced postmortem changes

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullis M.D. Medical Examiner.
Date signed 8-28-48

over

X

666455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 666455

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard and Saratoga Sts
(c) Hospital or institution: Hutzler Bros. Dept. Store
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4113 Chatham Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Schapiro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March, 10, 1907

8. AGE: Years	Months	Days	If less than one day
41	4 5	22	hr. min.

9. Birthplace Conn (Town, county, and state)

10. Usual Occupation

11. Industry or business Registered Nurse

FATHER
12. Name Aaron Selig Baker
13. Birthplace Russia

MOTHER
14. Maiden Name Elizabeth Leibman
15. Birthplace Russia

16 (a) Informant Louis Schapiro
(b) Address 4113 Chatham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3, 1948 (month) (day) (year)
(c) Cemetery or crematory Princess Ann Cemetery
Location Norfolk Va

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1126 W North Ave

19 (a) SEP 2 - 1948 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1 1948 at 4 1/2 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D. Medical Examiner
Date signed 9-1-48

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BC = 48-16396

G66456

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66456 Registered No. 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Lutherville
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Clark Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Tyler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/4/48

8. AGE: Years	Months	Days	If less than one day
		25	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Robb Tyler
13. Birthplace

MOTHER 14. Maiden Name Elizabeth Worthington
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 SEP 2 - 1948 (Date rec'd by Registrar) (b) Worthington Hollingsworth, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1948, at 12 NP M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 1948 to 8/29 1948 and that I last saw him alive on 8/29 1948.

Immediate cause of death PREMATURITY

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no) (Specify yes or no)
(e) Means of injury

23. Signature Alan C Thomas M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66457 B-48-2559 94 ✓ 666457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 666457

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 S. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Kazzynski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/28/48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Marion Kazzynski
13. Birthplace Md

MOTHER
14. Maiden Name Nanda Goscinski
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director Hart Funeral
(b) Address

19 (a) FEB 2 1948 (b) Huntington Woods, Mich.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28 1948, to 8/29 1948, and that I last saw h[illegible] alive on 8/29 1948.

Immediate cause of death PREMATURITY

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan C Hermann M. D.

Address JOHNS HOPKINS HOSPITAL Date signed

666458 BC-48-12826 ✓ 666458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 666458

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Williman Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Jones (1,6454)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	black	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/22/48

8. AGE: Years	Months	Days	If less than one day
0	0	5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name George Fitzgerald
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Doris Jones
15. Birthplace Baltimore, Maryland

16 (a) Informant Hospital Records
(b) Address The Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) SEP 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1948, at 4:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 22 1948, to August 27 1948, and that I last saw her alive on August 27 1948.

Immediate cause of death Kernicterus

Due to Hyperbilirubinemia Jaundice neonatorum

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Autopsy Kernicterus enlarged liver & spleen

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul D Bruns M. D.
Address The Johns Hopkins Hospital Date signed 8-27-48

VS 150

161c

N.H. 4 W

66459 BC-48-02719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

85

Registered No. 66459

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 / 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-3-48

8. AGE: Years | Months: 7 | Days | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joe Brown
13. Birthplace N.C.

MOTHER 14. Maiden Name Carrie Rambert
15. Birthplace N.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Baltimore, Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1 Bdantley ave Barrington for Williams, Md

19 (a) SEP 2- 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31-1948, at 6:39 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28-1948 to 8-31-1948 and that I last saw h alive on 8-31-1948

Immediate cause of death: Cerebral Anoxia — Duration

Due to Status Epilepticus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton Markowitz M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

666460 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Hollendia (Allender)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Will Allender
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Garfield Allender
(b) Address 1714 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2-48 (month) (day)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy O Wilson
(b) Address 1005 Bloomsbury ave

19 (a) SEP 2 - 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1948, at 5:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Chronic Alcoholism
Laceration at head
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/28/48 at about 5:00 P.M.
(b) Where did injury occur? Mercy Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? hospital While at work? No
(d) Means of injury Jumped from 5th floor window

23. Signature D. J. Sullivan M.D.
Medical Examiner.
Date signed 8/30/48

G66461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G66461 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3606 ST. MARGARET ST.
(c) Hospital or institution: BEDSKLYN, MD
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3606 ST MARGARET ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** GEORGE FILIPIAK

3 (b) If veteran, name war —
3 (c) Social Security Account No. — —

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. WIDOWED
6 (b) Name of husband or wife ANNA (NEINTZ)
6 (c) If alive, give age D years
7. Birth date of deceased (mo., day, yr.) 1875
8. AGE: Years 73 | Months | Days | If less than one day hr. min.
9. Birthplace AUSTRIA (Town, county, and state)
10. Usual Occupation MINER
11. Industry or business —

FATHER
12. Name UNKNOWN
13. Birthplace AUSTRIA

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace AUSTRIA

16 (a) Informant MR PETER FILIPIAK
(b) Address 3606 ST MARGARET ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory TRANSFIGURATION CEM
Location SHAMOKIN, PA.

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGAT ST. -30

19 (a) SEP 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams Jr. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 1, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1948 to Sept 1 1948 and that I last saw him alive on Aug 31 1948.

Immediate cause of death: coronary occlusion — Duration
Due to: hypertension
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Philip H. Kueter M. D.
Address 302 Patapsco Ave Date signed 9/2/48

G66462

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 166

Registered No. G66462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 445 Little Monument St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME HENRY CALLAHAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 6 1913

8. AGE: Years 35 | Months — | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace S. C. (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Grant Callahan
13. Birthplace S. C.

MOTHER 14. Maiden Name Mattie Talbott
15. Birthplace S.C.

16 (a) Informant Minnie Callahan
(b) Address 470 - W Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location Halstead

18 (a) Funeral director A. J. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) SEP 2 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1948, at 10 a.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wounds of lungs

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury August 29 1948 9:30 a.M.
(b) Where did injury occur? Druid Hill Ave. & Pace St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Firearms

23. Signature [illegible] G. Merrill M.D.
Medical Examiner.
Date signed 8/30/48

VS 151

X

666463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Register No. 666463

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2522 Wilkens Avenue
(c) Hospital or institution:
2015
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2522 Wilkens Avenue
(Also give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Greece

3 (a) FULL NAME PETER PAHOULIS

3 (b) If veteran, name war ** | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894 ?

8. AGE: Years 54 ? | Months | Days | If less than one day: hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Restaurateur

11. Industry or business

FATHER 12. Name John Pahoulis
13. Birthplace Greece

MOTHER 14. Maiden Name Unknown
15. Birthplace Greece

16 (a) Informant George S. Agnew
(b) Address 39 Murdock road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/48 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox
Location Evangelismos

18 (a) Funeral director Geo. S. Agnew Sons, Homewood
(b) Address 4 & N. Mt. Royal Ave.

19 SEP 2 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948 at 5:15 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Anemia

Due to Gastric ulcer

Other Conditions Malnutrition
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Where? work?)
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner
Date signed 31 Aug 48

X

VS 131

666464 JL - 122072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1548

Registered No. 666464

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Rupp

3 (b) If veteran, name war [redacted]
3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife John Rupp
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. April 30, 1861

8. AGE: Years	Months	Days	If less than one day
87	4	1	hr. min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James Baker
13. Birthplace England

MOTHER
14. Maiden Name Charlotte Percy
15. Birthplace England

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) SEP 2 - 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1948, at 1.25 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1948 to Sept. 1 1948.
and that I last saw her alive on Sept. 1 1948.

	Duration
Immediate cause of death Bronchopneumonia	days
Due to Acute CHF	wks.
Due to	
Other Conditions ASCVD	

(Include pregnancy within 3 months of death)

Date of operation 8/23/48
Major findings of operation: Carcinoma of the rectum, Dukes
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Isador Gadd M. D.
Address [redacted] Date signed 9/1/48

VS 150

666365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666365

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 600 S. Chapelgate Lane

(c) Hospital or institution: Pine Crest Sanatarium

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balti.

(c) City or town (If outside city or town limits write RURAL and name town)

(d) Street No. 1000 E Preston St (If rural give location)

(e) Citizen of foreign country? Yes or No

If yes, name country

3 (a) FULL NAME Katherine Hennick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Feb. 20, 1867

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/20/67

8. AGE: Years	Months	Days	If less than one day hr.	min.
81	6	11		

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Antone Ruppenger

13. Birthplace Germany

MOTHER

14. Maiden Name Mary Zieglar

15. Birthplace Germany

16 (a) Informant Mrs. Katherine Cole

(b) Address 1000 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3/48 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 908 East Biddle St.

19 (a) SEP 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1948, at 1 A M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1 1948 to August 31 1948 and that I last saw her alive on August 31 1948

Immediate cause of death Chronic Myocarditis & Myocardial Degeneration

Due to Senility

Due to

Other Conditions Hypostatic pneumonia (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

?

2/45

PHYSICIAN

Underline the one to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence At M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Melvin N. Borden M. D.

Address 2230 W Fayette St Date signed 9/1/48

666466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

666466 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)

(d) Street No. 210 Upnor Road (If rural, give location)

(e) Citizen of foreign country? No Yes or No

If yes, name country

3 (a) FULL NAME Mrs. Regina L. Hisley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Joseph M.

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr) 2/27/90

8. AGE: Years	Months	Days	If less than one day: hr.	min.
58	6	4		

9. Birthplace Baltimore, Maryland (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER	12. Name	James A. Logue
	13. Birthplace	Balto
MOTHER	14. Maiden Name	Harriet Lucas
	15. Birthplace	Balto.

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4, 1948 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Windfield

(b) Address 900 Earl Biddle St.

19 (a) SEP 2 - 1948 (Date received by registrar) (Signature of registrar) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1948 at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1948 to Aug 31 1948 and that I last saw h[illegible] alive on Aug 31 1948.

Immediate cause of death Coronary Occlusion — Duration

Due to Arterio-sclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, in industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ray E. Pierson Jr. D

Address St. Joseph's Hospital Date signed 8/31/48

VS 150

To be approved by Medical Examiner

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

191

Registered No. G66467

G66467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered, if correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1402 N. Carolina St.,

(c) Hospital or institution: St. Joseph Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr. Sudd.

(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4514 Frankford Ave, Balto. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME George Ignatius Groeninger

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 213-05-1753

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Margaret Mary

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): July 31, 1888

8. AGE:

Years	Months	Days	If less than one day
60	0	30	hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Packer - Burroughs Bros.

11. Industry or business:

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant: Margaret Mary Groeninger

(b) Address: 4514 Frankford Ave, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-48 (month) (day) (year)

(c) Cemetery or crematory: Holy Redeemer

Location: Balto

18 (a) Funeral director: L. J. Ruck

(b) Address: 5305 Harford Rd.

(c) Date received by registrar: 9-2-1948 (b) Harrington Williams, M.D. Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 19 48 at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 19 48 to Aug 30 19 48, and that I last saw him alive on Aug 30 19 48.

Immediate cause of death: Hyperpyrexia — Duration

Due to: Hyperpyrexia from Heat Stroke

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature: John M. Rehfuss M. D.

Address: St. Joseph Hospital Date signed: Aug 30, 1948

For D. H. Davis & Howard J. Mackesi M.D.

G666468

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G666468

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1100 N. Caroline Street

(c) Hospital or institution: St. Joseph's Hospital 26-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)

(d) Street No. 5103 Anthony Avenue (If rural give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Mr. James Bernard Kerby

3 (b) If veteran, name war None

3 (c) Social Security Account No. 205-07-6542

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine Frances Morwood

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr) April 21, 1896

8. AGE: Years 52 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Renova, Pennsylvania (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business B & O Railroad

FATHER

12. Name Frederick Kerby

13. Birthplace Pennsylvania

MOTHER

14. Maiden Name Sarah Mulvihill

15 Birthplace Pensylvania

16 (a) Informant Mrs. Catherine F. Kerby -Wife

(b) Address 5103 Anthony Avenue

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9-4-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road, Balto. Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

SEP 2 - 1948 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1948, at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29-48 19 to 8-31- 19 48, and that I last saw him alive on 8-31-48 19

Immediate cause of death Coronary Occlusion — **Duration**

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Ray E. Pisano Jr.

Address St. Joseph's Hosp. Date signed 8/31/48

VS 150

G66369

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66369
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 Kennedy Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac D. Bloom

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Emma F. Mitchell
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Feb. 27th., 1883

8. AGE: Years	Months	Days	If less than one day
65	6	4	##### hr. ..... min.

9. Birthplace New York State (Town, county, and state)
10. Usual Occupation Billiard Room Proprietor
11. Industry or business

FATHER
12. Name Ross Bloom
13. Birthplace New York State

MOTHER
14. Maiden Name Elizabeth Levis
15. Birthplace New York State

16 (a) Informant Mrs. Emma F. Bloom - Wife
(b) Address 2014 Kennedy Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location E. North Avenue Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1785 Harford Avenue

19 (a) 1948 (Date received by registrar) Huntington Williams, Mgr.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1948, at 11:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions Bronchiectasis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at .....
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. P. Falvo M.D. Medical Examiner.
Date signed 8/31/48

VS 151

G66470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66470

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 Worsley St.
(c) Hospital or institution:
12 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Worsley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23-1901

8. AGE: Years	Months	Days	If less than one day
46 47	11	8	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name James Green

13. Birthplace Va

MOTHER 14. Maiden Name Mattie

15. Birthplace Va

16 (a) Informant Arthur Green

(b) Address 408 Worsley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-48

(c) Cemetery or crematory Mt. Olivet Cemetery

Location Baltimore

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

(c) Date received SEP 2 1948 (b) Filing Clifton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1948, at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Morgan H. Merrill M.D. Medical Examiner.

Date signed 9-4-48

VS 151

X

BC-G30576

G66471

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 14

G66471 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & SARATOGA
(c) Hospital or institution: MERCY HOSP. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mo. 8d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3204 MARY AVE. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID RHEA (DAVID EDGAR RHEA)

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 22, 1945

8. AGE: Years 3 | Months 1 | Days 4 | If less than one day: hr. min.

9. Birthplace BALTIMORE, Md (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name EDGAR RHEA.
13. Birthplace WASHINGTON D.C.

MOTHER
14. Maiden Name CHARLOTTE MILLER
15. Birthplace BALTIMORE, Md

16 (a) Informant Mr. Edgar S. Rhea
(b) Address 3204 Mary Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/3/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 2 1948 (Date received by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1st 1948 at 6:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1948. to Sept 1 1948. and that I last saw him alive on Aug 31 1948.

Immediate cause of death: Resp failure — Duration

Due to Tuberculous Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation and of autopsy: Autopsy Tuberculous Meningitis & internal hydrocephalus

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Frank L. Avonte, M.D.
Address Mercy Hosp. Date signed 9/1/48

VS 150

G66472 ✓ G66472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 Clinton st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK (KOUKAL) Koukol

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie Koukol (Koukal)
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1876

8. AGE: Years 71 | Months 9 | Days 19 | If less than one day / hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Pipe Maker

11. Industry or business

FATHER 12. Name Frank Koukol (Koukal)
13. Birthplace Bohemia

MOTHER 14. Maiden Name Centonec
15. Birthplace Bohemia

16 (a) Informant Marie Koukol
(b) Address 1509 Clinton st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-4-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore County

18 (a) Funeral director Hugh Corpe & Son
(b) Address 1200 W. Baltimore st

19 (a) 8-2-48 (Date filed by Registrar) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1948, at 8-40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/23 1948, to 9/1 1948, and that I last saw him alive on 9/1 1948.

Immediate cause of death: Hemopneumothorax, bilat.
Pulmonary embolism, rt.
Due to: Carcinoma of esophagus

Duration: 1 day ? hrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation 8/31/48
Major findings of operation: Carcinoma of esophagus
of autopsy: a above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn O. Summerlin
Address 1213 Light St. Date signed 9/1/48

VS 150

G66473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66473 Registered No.

48 C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkens ave

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 111 Smith wood ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Sue H. Larkin

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	M.

6 (b) Name of husband or wife: Allan J.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 17, 1894

8. AGE: Years	Months	Days	If less than one day: hr.	min.
54	7	19		

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual Occupation: House wife.

11. Industry or business

FATHER

12. Name: Peter Scheidel

13. Birthplace: Pa. (dec'd)

MOTHER

14. Maiden Name: Caroline Ruff.

15. Birthplace: Germany (dec'd)

16 (a) Informant: Husband

(b) Address: Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-48 (month) (day) (year)

(c) Cemetery or crematory: National Cem. Location: Baltimore

18 (a) Funeral director: George A. Fearley

(b) Address: Fulton ave & Fayette St.

19 (a) Sept 2- 1948 (Date rec'd by registrar) (b) Huntington Wilkinson (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31/1948, at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1948 to 8/31 1948 and that I last saw h— alive on 8/31 1948.

Immediate cause of death: GENERALIZED CARCINOMATOSIS

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Peter B. Steer M.D.

Address 1 E. Lexington St Date signed 9/2/48

G66474 ✓ G66474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: CHILDREN'S HOSPITAL SCHOOL
(a) Baltimore City, Maryland
(b) Street address GREENSPRING AVE. NEAR KEYWORTH
(c) Hospital or institution: CHILDREN'S HOSPITAL SCHOOL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 POPLAR GROVE ST. (16) (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME JOHN JAMES POWERS

3 (b) If veteran, name war: WORLD WAR II
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: DOROTHY VIRGINIA SCHISTER POWERS
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-14-'24
8. AGE: Years 23 | Months 11 | Days 18 | If less than one day hr. min. 17
9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation NONE RECENTLY
11. Industry or business —

FATHER
12. Name SUMNER POWERS
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name ANNA APPLER
15. Birthplace BALTIMORE, MD.

16 (a) Informant WIFE
(b) Address 2102 POPLAR GROVE ST. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-1948 (month) (day) (year)
(c) Cemetery or crematory Lloyd Ridge
Location Pikesville, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3707 W. North Ave

19 (a) SEP 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 1 1948, at 7:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1948, to 9-1 1948, and that I last saw him alive on 9-1 1948.

	Duration
Immediate cause of death: CARDIAC FAILURE	15 MIN
Due to: VIRUS BRONCHITIS	1 WK.
Due to: POST-POLIOMYELITIC RESPIRATORY & GENERALIZED PARALYSIS	1 YEAR
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation: 0
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature O. Donald Thieman M.D.
Address Children's Hospital School Date signed 9-1-48

VS 3

1 X

G66475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G66475

-PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkens ave.
(c) Hospital or institution:
St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Wolfblook ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie M. LeHr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband ~~or wife~~ JOHN LEHR

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 7. 1869

8. AGE: Years 79 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Jacob Hoffman dec'd

13. Birthplace Md.

MOTHER 14. Maiden Name Barnard.

15. Birthplace ?

16 (a) Informant Daughter.

(b) Address Same.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-1948 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore Md.

18 (a) Funeral director D. Howard Strong

(b) Address 3207 W. North Ave.

19 (a) SEP - 1948 (Date rec'd by registrar) (b) Huntington Williamsport Pa. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31 1948 at 1.40 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1948 to 8-31 1948 and that I last saw h[illegible] alive on 8-31 1948.

Immediate cause of death Acute Renal Failure.

Duration

Due to Intestinal Obstruction.

Due to Cachexia.

Other Conditions Diabetes mellitus.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Outlaw T. Hare Jr. M.D.

Address St. Agnes Hosp. Date signed 8/31/48

VS 153

1221R

G66476

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. G66476

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Streets
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life-ind.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4216 NORTH CHARLES ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. MABEL E. LEIGH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife THOMAS B. LEIGH
6 (c) If alive, give age · years

7. Birth date of deceased (mo., day, yr.) 4-12-1873

8. AGE: Years	Months	Days	If less than one day hr.	min.
75	4	19		

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE,
11. Industry or business

FATHER
12. Name MR. CHARLES ALBERT THOMAS
13. Birthplace MARYLAND

MOTHER
14. Maiden Name REBECCA ELLEN SOPER
15. Birthplace MARYLAND

16 (a) Informant THOMAS B. LEIGH
(b) Address 4216 NORTH CHARLES ST, BALT. MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 2 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1 1948 at 9 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1948 to 9-1 1948 and that I last saw HER alive on 9-1 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 da.
Due to Hemorrhagic Purpura unknown Etiology — 2 wk.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Negative

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature H. R. Freeman, Jr.
Address 11 W. 29th ST Date signed Sept 1, 1948

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G66477 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd + Calvert

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d.

(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5308 Tramore Rd (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME William Carroll Clark

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Floss Clark nee Caple

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1889 2-3-89

8. AGE: Years 59 | Months 6 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Insurance Broker

11. Industry or business Secretary & Treasurer Warfield & Dorsey Co.

FATHER

12. Name. Agustus B. Clark

13. Birthplace Baltimore, Md

MOTHER

14. Maiden Name Elizabeth S. Brown

15. Birthplace Baltimore, Md.

16 (a) Informant Roland A. Clark (son)

(b) Address 4407 Arabia Ave. Baltimore

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof 9/4/48 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (Date received by Registrar) SEP 2 - 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2, 1948 at 2:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 28 August 1948 to 2 Sept 1948 and that I last saw h in alive on 1 Sept 1948

Immediate cause of death: Pulmonary embolism — Duration

Due to: Post-op amputation Rt Leg Thrombo-angiitis, obliterans

Due to:

Other Conditions: Arteriosclerotic heart disease Rheumatoid Arthritis

(Include pregnancy within 3 months of death)

Date of operation 8-24-48

Major findings of operation: Supra condylar amputation rt leg.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify)

(e) Means of injury

23. Signature McAlpin Arnold M.D.

Address Union Mem. Hospital Date signed 9-2-48

PHYSICIAN

Underline the cause to which death should be charged statistically.

99

VS 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66478

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52B

Registered No. G66478

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Larchmont (If outside city or town limits, write RURAL and give town)
(d) Street No. 5903 Gwynn Oak Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Ida S. Robinson

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Inglis Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 5, 1870

8. AGE: Years 78 | Months 0 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William H. Rynehart
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Dillon
15. Birthplace Martinsburg, W. Va.

16 (a) Informant Mrs. S. Elizabeth Smith
(b) Address Old Court Rd., Woodstock, Md.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9/6/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 2 1948 (Date rec'd by registrar) **(b)** Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2/48 19 . at 2 1/4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/48 19 , to 9/2/48 19 , and that I last saw her alive on 9/2/48 19 .

Immediate cause of death Cardiac failure — **Duration**

Due to Hypertension Arteriosclerosis

Due to

Other Conditions Carcinoma of Bladder with secondary tumors

(Include pregnancy within 3 months of death)

Date of operation 9

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?
(e) Means of injury

23. Signature Frank E Braunbeck M. D.
Address Owensville, Md. Date signed 9/2/48

VS 150

1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

Registered No. 666479

666479

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1933 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSA N. GARNAND

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: William T. Garnand

6 (c) If alive, give age (years)

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1870

8. AGE: Years 78 | Months 6 | Days 11 | If less than one day: hr. min.

9. Birthplace New York City (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frederick Gebhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. L. Stein
(b) Address 3610 Hineline Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 2 - 1948 (b) Huntington Williams, M.D. Address 438 Cathedral St.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1948 8:00 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from July 30 1948 to Sept 1 1948, and that I last saw h[illegible] alive on Sept 1 1948

Immediate cause of death: Hypostatic Pneumonia — Duration: 2 days

Due to: Chronic Gen. Arteriosclerosis — Duration: several years

Due to: [illegible]

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H W Keown M.D. Date signed 9/1/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 153

PORSINGER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 50

666460

Registered No. 666460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 524 S Streeper
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 N. Streeper St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillian A Porsinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frederick Porsinger

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): 1878

8. AGE: Years: 70 | Months | Days | If less than one day: hr. | min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business: At Home

FATHER
12. Name: James Bozer
13. Birthplace: Balto

MOTHER
14. Maiden Name: Margaret Bunnis
15. Birthplace: Balto

16 (a) Informant: Mrs Rose Lastinski
(b) Address: 524 S Streeper

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-1-3- (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cem
Location: City

18 (a) Funeral director: Ulrich Funeral Home
(b) Address: 2008 Gilmore St Huntington Station, Md

19 SEP 2 - 1948 (Date rec'd by registrar) (b) Registrar

VS 80

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1948, at 2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to Aug 31 1948, and that I last saw her alive on Aug 31 1948

Immediate cause of death Carcinoma of Breast — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Eugene Zeller, M.D.

Address 2739 Eastern Ave Date signed 8/31/48

G66481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. G66481

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1520 STONEWOOD RD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Stonewood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA M. RINEHART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 18, 1863

8. AGE: Years	Months	Days	If less than one day
85	7	13	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name LOUIS RINEHART
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ANNIE PENN
15. Birthplace MARYLAND

16 (a) Informant MRS GEORGE SMISSRAT
(b) Address 1620 STONEWOOD RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 3 1948 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE

18 (a) Funeral director Henry H Wittyke
(b) Address 4601 Edmondson Ave Catonsville, Md.

19 SEP 2- 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 31 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1948 to Aug. 31 1948, and that I last saw her alive on Aug 31 1948.

Immediate cause of death Cardiac failure — Duration 3 wks.

Due to Arteriosclerotic and hypertensive heart disease — ?

Due to Coronary Sclerosis

Other Conditions Senility, Cellulitis of face

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Burgin M.D.
Address 6721 Reisterstown Rd Date signed Sept. 1

VS 150

66482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43

Registered No. 66382

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1731 Park Avenue

(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 10

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1731 Park Avenue (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME THELMA GROTH BENDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife J. Luther Bendt

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr) July 23, 1909

8. AGE: Years	Months	Days	If less than one day
39	1	8	hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Home maker

11. Industry or business

FATHER 12. Name HANS H. GROTH

FATHER 13. Birthplace DENMARK

MOTHER 14. Maiden Name MATHILDA M

MOTHER 15. Birthplace U.S.A.

16 (a) Informant ~~Self~~ J. Luther Bendt

(b) Address 1731 Park Avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 4 1948 (month) (day) (year)

(c) Cemetery or crematory MORELAND MEMORIAL

Location TAYLOR AVE

18 (a) Funeral director Harry H. Withe

(b) Address 4101 Edmondson Ave

19 SEP 2 1948 (b) Huntington Pallisades, Md. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1948, at 8:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1945 to Sept 1 1948, and that I last saw her alive on August 1948.

Immediate cause of death ~~Heart Attack~~ Medullary Failure — Duration

Due to Increased Intracranial Pressure

Due to Central Nervous System Torulosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William F. Tillery M.D.

Address 13 W. Madison St. Date signed 9/1/48

VS 150

G66483

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 117a

G66483 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16-
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3524 Edmondson Ave #29 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Burke Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-7788

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/12/91

8. AGE: Years 57 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business THOMAS HICKS + SONS

FATHER
12. Name CHARLES E BURKE
13. Birthplace MD.

MOTHER
14. Maiden Name ANNE HINES
15. Birthplace MD

16 (a) Informant MRS ROBERT BURKE
(b) Address 3524 EDMONDSON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 3, 1948 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE

18 (a) Funeral director Harry A Wyse
(b) Address 4101 Edmondson Ave

19 (a) SEP 1 1948 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1948, at 11 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 19 48, to 8/31 19 48, and that I last saw h alive on 8/31 19 48

Immediate cause of death Cardiac failure

Due to Coronary thrombosis

Due to Arteriosclerosis

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Coronary thrombosis Hypertension

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E J Blazek M.D. Address Maryland General Date signed 8/31/48

94a

G66484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66484

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 600 N. Chapelgate Lane

(c) Hospital or institution: Fernest Sanatarium

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Carroll

(c) City or town Hampstead (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of (foreign country)? No Yes or No

If yes, name country

3 (a) FULL NAME Leander E Albaugh

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W.

6 (b) Name of husband or wife Alice Albaugh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27-1861

8. AGE: Years 87 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Retired painter

11. Industry or business

FATHER 12. Name John Albaugh

13. Birthplace Md

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Mrs Howard Albaugh

(b) Address Hampstead Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5-'48 (month) (day) (year)

(c) Cemetery or crematory Hampstead

Location Carroll Co Md

18 (a) Funeral director Edw Clifton

(b) Address Hampstead Md

19 SEP 2 - 1948 (b) Huntington Williams, Mgr Registrar

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1948, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948, to September 1 1948, and that I last saw h/m alive on Sept. 1 1948

Immediate cause of death	Duration
Senility with senile dementia	2 yrs
Due to Arteriosclerosis	
Due to	
Other Conditions Enlarged heart	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify) (type of place)

(e) Means of injury

23. Signature Melvin M. Bowlan M. D.

Address 233 N Fayette St Date signed 9-1-'48

97

666385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666385

FILE NUMBER 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3039 Shannon Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 47 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3039 Shannon Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William R. Dayton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife Vic Dayton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	26	hr. min.

9. Birthplace Western Maryland
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Charles Dayton
13. Birthplace ?

MOTHER
14. Maiden Name Thomasine Muia
15. Birthplace ?

16 (a) Informant Mrs. Dale
(b) Address 3039 Shannon Drive

17 (a) Removal (b) Date thereof Sept. 3, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Western Cem., Md.

18 (a) Funeral director John A. Moran
(b) Address 3006 E. Baltimore St

19 (Date received) SEP 2 1948 (Registrar) Washington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2 1948 at 11:25 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions Arteriosclerotic C.V. disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. Schwartz M.D.
Medical Examiner.
Date signed 9/2/48

G66486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G66486 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania County
(c) City or town Scranton (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 Rossuna Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Magdalena Laureska

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband ~~or wife~~ Anthony Laureska

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years about 69 | Months | Days | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Simon Wilkes

13. Birthplace Lithuania

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant The Seton Institute,
(b) Address 6420 Reisterstown Rd., Balto 15 Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 3 1948 (month) (day) (year)

(c) Cemetery or crematory St. Catherine
Location Moscow - Penna.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (U. S. WOODSON SUB.) 100 N. BOND AVENUE

19 (a) (b)
(Date rec'd by registrar) Registrar

SEP 2 - 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1948, at 1 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7 1948 to 9-2-48 1948, and that I last saw h~~er~~ alive on 9/2/47 19.

Immediate cause of death — Duration
Cardio - Resp failure

Due to Recurrent carcinoma of the breast with

Due to metastases

Other Conditions arteriosclerotic heart disease and Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. L. Meiers M.D. M. D.
Address Seton Institute Date signed 9/4/48

X

66487

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66487

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll Co
(c) City or town Manchester, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Lydia L. Snyder

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Jacob W. Snyder deceased
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Sept 6, 1865

8. AGE: Years 83 | Months 11 | Days 23 | If less than one day: hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John W. Greenfelt
13. Birthplace Littlestown, Pa.

MOTHER
14. Maiden Name Anna Bixler
15 Birthplace Carroll Co. Md.

16 (a) Informant Mrs. J. Peter
(b) Address 1600 Broadway
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-4-48 (month) (day) (year)
(c) Cemetery or crematory Lemptons
Location Manchester, Md.
18 (a) Funeral director Jacob Wm. Bair Sons
(b) Address Manchester, Md.
19 SEP 3 - 1948 (Date rec'd by Registrar) (b) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2, 1948 at 6 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30, 1948 to Sept 2 1948 and that I last saw h[illegible] alive on Sept 2 1948

Immediate cause of death Terminal Broncho Pneumonia - due to Senility — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest Lewis, M.D.
Address 1601 N. Broadway Date signed 9/2/48

G66488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G66488

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State No. Carolina (b) County GATES
(c) City or town CRAPEAK (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH ANN WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) APRIL 4, 1943

8. AGE: Years	Months	Days	If less than one day
5	4	29	hr. min.

9. Birthplace NORTH CAROLINA (Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business

FATHER
12. Name NORFLEET WHITE
13. Birthplace NORTH CAROLINA

MOTHER
14. Maiden Name DOROTHY BRINKLEY
15. Birthplace NORTH CAROLINA

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 3/48 (month) (day) (year)

(c) Cemetery or crematory Eureka Church Location N. Cgo

18 (a) Funeral director Wells Funeral Home

(b) Address 2008 Orleans St

19 (a) SEP 2 - 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 2 1948, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1948, to 9-2 1948, and that I last saw HER alive on 9-2 1948.

Immediate cause of death	Duration
Brain Abscess	
Due to Cause Undetermined	
Due to	
Other Conditions Congenital Heart Disease Tetralogy of Fallot (Include pregnancy within 3 months of death)	

Date of operation Sept 1, 1948

Major findings of operation: Left Frontal Brain Abscess

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Daleally M. D.

Address JOHNS HOPKINS HOSPITAL Date signed Sept 2, 1948

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. 66489

66489

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 432 S PATTERSON PK AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 S. Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE CATON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married, widowed~~, or divorced: Divorced

6 (b) Name of husband ~~or wife~~ Leo Caton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4th 1892

8. AGE: Years 56 | Months 4 | Days 28 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name Chas. Hz Jeotay
13. Birthplace Md.

MOTHER 14. Maiden Name Mary E. Reardon
15. Birthplace Md.

16 (a) Informant Mrs. James Hart
(b) Address 246 E. North Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory St Mathias
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 S. Paul St.

19 (a) SEP 3 - 1948 (Name rec'd by registrar) Washington-Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2 1948 at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1948 to 9/2 1948 and that I last saw h[er] alive on 9/1 1948.

Immediate cause of death: Cardiac and respiratory failure — Duration
Due to: Coronary thrombosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature Louis D. Pratt, M.D.
Address 900 E. Northern Pkwy Date signed 9/3/48

VS 150

666490

Kohlman

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 937

666490 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) ~~Hospital~~ or institution: Maryland General 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL ~~RESIDENCE~~ OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2015 Eutaw Place # 17 (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ella Gertrude Kohlman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband Edward G. Kohlman

6 (c) If ~~alive~~, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 1880

8. AGE: Years 67 | Months 11 | Days 26 | If less than one day hr min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name George Suter

13. Birthplace Md.

MOTHER 14. Maiden Name Katherine Kelley

15. Birthplace Ireland

16 (a) Informant Edward G. Kohlman

(b) Address 2015 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Cathedral

Location Balto. Md.

18 (a) Funeral director Wilkins Cook Inc.

(b) Address 1217 E. Fayette St.

19 (a) SEP 3 1948 (Date rec'd by registrar) (b) Huntington Williams, Inc. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1948 at 7 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/29 1948 to 9/1 1948, and that I last saw h alive on 9/1 1948

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebrovascular accident	4 days.
Due to Hypertension Cerebrovascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Cerebrovascular cause

PHYSICIAN

(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward J. Black, M.D.

Address Maryland General Date signed 9/1/48

VS 153

G66491 C 74037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G66491 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 N. Spring St.
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 107d.
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 N. Spring St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fanny Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/24/47

8. AGE: Years	Months	Days	If less than one day
1	5	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Robert Thomas
13. Birthplace Boston, Mass.

MOTHER
14. Maiden Name Ernestine Booker
15. Birthplace Baltimore Md.

16 (a) Informant Mother
(b) Address absent

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Local Public Health Medical Orders AUG 25 1948

18 (a) Funeral director
(b) Address

SEP 3 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 1948 at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 12 1948 to Aug 6 1948.
and that I last saw he alive on 8/6 1948

Immediate cause of death
Tuberculous Meningitis

Duration 107 d.

Due to

Due to

Other Conditions Hydrocephalus

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. O. Goldenberg
Address Sydenham Hosp. Date signed 8/8

V S 190

G66492

BCv48-17804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G66492

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Univ. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Carroll

(c) City or town Westminster (If outside city or town limits, write RURAL and give town)

(d) Street No. 253 E. Main St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Stanbaugh

3 (b) If veteran, name war 0

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/15/48

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace Univ. Hosp. (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Donald J. Stanbaugh

13. Birthplace

MOTHER 14. Maiden Name Doris Fees

15. Birthplace Md

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location University Medical School AUG 24 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) SEP 2 1948 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15 1948 at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1948 to 8/15 1948 and that I last saw h/ alive on 8/15 1948

Immediate cause of death — **Duration**

Due to Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature Robert D. Brown M.D.

Address Univ. Hosp. Date signed 8/16/48

VS 150

666493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC- 48-17960

159 1/2

666493

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison and Fenhorn Ave.

(c) Hospital or institution: Md. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hr.

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Balto.
(If outside city or town limits, write RURAL, and give town)

(d) Street No. 3343 Belair Rd.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Butschky

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-19-48

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name George Henry Butschky

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Myrtle L. Johnson

15. Birthplace Balto. Md.

16 (a) Informant George Henry Butschky

(b) Address 3343 Belair Rd.

17 (a) _____ (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School AUG 24 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 3 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20-48 19 , at 3 10/A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19-48 19 , to 8-20-48 19 , and that I last saw him alive on 8-20-48

Immediate cause of death

Duration

Due to Cardiac Vascular Failure

Due to Prematurity

Other Conditions Atelectasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Thomas C. Wilson M.D.

Address Md Gen. Hosp Date signed 8/20/48 M.D.

VS 153

X

BC-48-1948 Kulich

G66494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G66494

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr 28 min

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3323 Virginia Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Infant - not baptized Baby Kulick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-2-48

8. AGE: Years | Months | Days | If less than one day: 1 hr. 28 min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER

12. Name Frederick Kulick

13. Birthplace Springfield Mass

MOTHER

14. Maiden Name Mildred Mary Clouse

15. Birthplace Baltimore, Md.

16 (a) Informant Mildred Kulick

(b) Address 3323 Virginia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/pt 3-48 (month) (day) (year)

(c) Cemetery or crematory St Pauls Cem.

Location Violetsville Md

18 (a) Funeral director Mrs Chas A G Robida

(b) Address 2327 Edmondson Ave

19 (a) SEP 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1948, at 8:24 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1948 to same day 1948, and that I last saw him alive on 9-2 1948.

Immediate cause of death Respiratory Failure — **Duration**

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. A. Peterson M. D.

Address University Hospital Date signed 9-2-48

VS 150

666495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666495

BR - 48-12066

161a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St. 525
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - 25 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Monroe Circle (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carolina Mildred Kimble

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Wht | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-31-48

8. AGE: Years | Months | Days 6 | If less than one day hr. min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Melvin Kimble
13. Birthplace Salisbury - Md

MOTHER 14. Maiden Name Gwendolyn Anderson
15. Birthplace Balto - Md

16 (a) Informant Mrs. Gwendolyn Kimble
(b) Address 1125 Monroe Circle

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Johns Hopkins Medical Schoo AUG 24 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 3 - 1948 (Date rec'd by registrar) (b) Lustington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1948 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31, 1948, to June 6 1948; and that I last saw her alive on June 6, 1948.

Immediate cause of death Pulmonary edema

Due to Incompletely aerated lungs

Due to

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph A. Kimmit

Address Sinai Hospital Date signed 8/23/48.

X

66496

BC-48-6618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

Registered No. 66496

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 Monument St
(c) Hospital or institution Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 das
(e) Length of stay in Baltimore (yrs., mos., or days) 2 das

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 Portugal St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James John Stanczyk - Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Wht	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-4-48

8. AGE: If under 1 year	Months	Days	If less than one day
2 das		2	hr. min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James J. Stanczyk - Sr
13. Birthplace Balto - Md.

MOTHER
14. Maiden Name Madeline Slowacke
15. Birthplace Balto - Md

16 (a) Informant Mrs Madeline Stanczyk
(b) Address 2002 Portugal St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Mount Hope Hebrew Sect. AUG 24 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (c) SEP 3 - 1948 (Date received by registrar) Huntington Woods Md (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 - 1948 at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1948 to June 6 1948, and that I last saw him alive on June 6 1948.

Immediate cause of death Pulmonary edema

Due to Incompletely aerated lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph A. Kennist M.D.
Address Sinai Hospital Date signed 8/23/48

666497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 666497

4P-18366

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - 15 (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Parkway Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Sulsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	wht.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-28-48

8. AGE: Years	Months	Days	If less than one day
NB			1 hr. min.

9. Birthplace Balto - Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harold Sulsky
13. Birthplace Balto - Md

MOTHER
14. Maiden Name Yetta Sonnenburg
15. Birthplace Balto - Md

16 (a) Informant Mrs. Yetta Sulsky
(b) Address 4014 Parkway Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Licensed Johns Hopkins Medical Schoo AUG 24 1948 Commissioner of Health

18 (a) Funeral director

(b) Address

19 (Date received by registrar) SEP 3 1948 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1948 at 10:55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/28 1948 to 6/28 1948, and that I last saw her alive on 6/28 1948.

Immediate cause of death Multiple malformations of kidneys and bladder

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence. at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph A. Kevins, M.D.
Address Sinai Hospital Date signed 8/23/48

666498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. 666498

C-48-15478

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address E. Monument St

(c) Hospital or institution: Sinai 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto - 15 (If outside city or town limits, write RURAL and give town)

(d) Street No. 3607 Park Heights Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Hurwitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-48

8. AGE: Years | Months | Days | If less than one day 2 hr. min.

116.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Benjamin Hurwitz

13. Birthplace Balto - Md.

MOTHER 14. Maiden Name Elva Blumenthal

15. Birthplace New York - N.Y.

16 (a) Informant Elva Hurwitz

(b) Address 3607 Park Heights Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Locat Johns Hopkins Medical Schoo AUG 24 1948

18 (a) Funeral director Commissioner of Health

(b) Address Westminster, Md

19 SEP 3 - 1948 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1948 at 9:20 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26 1948 to 7-26 1948 and that I last saw him alive on 7-26 1948.

Immediate cause of death Subarachnoid hemorrhage — Duration

Due to Prematurity Labor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph A. Kuntz M. D.

Address Sinai Hospital Date signed 8/23/48

666499

BC-48-17607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

Registered No. 666499

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address E. Monument St

(c) Hospital or institution Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 5 Hrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto-24 (If outside city or town limits, write RURAL and give town)

(d) Street No. 1415 Georgian St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME Joseph Francis Dauses

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/18/48

8. AGE: Years	Months	Days	If less than one day
1/12			5 hr. 5 min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Francis Joseph Dauses

FATHER 13. Birthplace Balto Md

MOTHER 14. Maiden Name Catherine Angeline Kesler

MOTHER 15. Birthplace Balto - Md

16 (a) Informant Catherine Dauses

(b) Address 415 Georgian St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Local Johns Hopkins Medical Schoo AUG 24 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) SEP 3 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1948, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1948 to 8-18 1948, and that I last saw h[illegible] alive on 8-18 1948.

Immediate cause of death Atelectasis both lungs

Due to Congenital defect in diaphragm with herniation of abdominal viscera into thoracic cavity

~~Duete~~ ~~Other Conditions~~

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph A. Kmint M.D.

Address Dindi Hosp. Date signed 8/29/48

G66500 — Birth - 48 - 16205 — G66500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 159

BC-48-16205

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts.

(c) Hospital or institution University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1270 Jones St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Omlor. OMLOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/5/48

8. AGE: Years	Months	Days	If less than one day
		11 12	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Robert Omlor

13. Birthplace RILTON W. VIRGINIA

MOTHER — 14. Maiden Name Helen HOLLY

15. Birthplace DAYTON OHIO

16 (a) Informant:

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School AUG 24 1948

18 (a) Funeral director Commissioner of Health

(b) Address Washington Wilkinson, MD

19 (a) Date received by Registrar SEP 3 1948 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948 at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1948 to 8/17 1948.

and that I last saw him alive on 8/17 1948.

Immediate cause of death	Duration
Respirations ceased	
Due to Prematurity	
Due to	
Other Conditions Djarrhea, dehydration (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature James W. Bisanar M.D. M. D.

Address University Hosp Date signed 8/17/48

666501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

666501

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 10 days

(e) Length of stay in Baltimore (yrs., mos., or days): ? 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County: Baltimore

(c) City or town: (If outside city or town limits, write RURAL and give town)

(d) Street No.: 632 Gold St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country:

3 (a) FULL NAME: LLOYD WILSON

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.: ?

4. Sex: M

5. Color or race: col

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hannah Wilson

6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr): Unknown

8. AGE: Years: ? 52 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Storekeeper

11. Industry or business: Own business

FATHER

12. Name: Leonard Wilson

13. Birthplace: Md.

MOTHER

14. Maiden Name: Lucy ?

15. Birthplace: ?

16 (a) Informant: Records

(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 7-48 (month) (day) (year)

(c) Cemetery or crematory: Balto Nat Cemetery

Location: Baltimore

18 (a) Funeral director: Va Brookes

(b) Address: 1468 N. Carey St

19 (a) SEP 3 1948 (Date rec'd by registrar) (b) Washington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 2 1948, at 2:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1948 to Sept. 2 1948, and that I last saw him alive on Sept. 2 1948.

	Duration
Immediate cause of death: Subarachnoid hemorrhage	11 days
Due to: Other conditions: Hypertensive cardiovascular disease	Unknown
Other Conditions: Diabetes mellitus	8 yrs

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: John L. Wilson

John L. Wilson, Sr. Surgeon M. D.

Address: Clinical Director Date signed: 9/3/48

VS 150

82a

G66502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G66502 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & SARATOGA.
(c) Hospital or institution: MERCY HOSPITAL 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12d.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALT.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 160 Gay ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Rudolph HERMAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife UNKNOWN.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/16/72

8. AGE: Years	Months	Days	If less than one day
75 76	11	1	hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation UNKNOWN.
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 24 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 AUG 3 1948 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15/48 19 . at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG 5 1948 to AUG 15 1948, and that I last saw him alive on AUG 14 1948

Immediate cause of death	Duration
PNEUMONIA	
Due to CEREBRAL thrombosis	
Due to AC cardiovasc. disease.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Joseph L. Arnold M.D.
Address Mercy Date signed 8/15/48

VS 159

666503

48-15427

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 666503 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 Greenmount Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 Greenmount Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALEXANDER UZZLE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 20 hr. 5 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 24 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 3 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1948 at 9:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester F. Lominski M.D. M.D.
Medical Examiner
Date signed 7-26-48

VS 151

G66504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 D

Registered No. 166504

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town write RURAL and give town)
(d) Street No. 48 Market Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Poulson or Carl Poulson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School AUG 24 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 3 - 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1948, at 7:30 PM

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, said death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH myocardial degeneration and chronic alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Rupp M.D.
Medical Examiner
Date signed 8/13/48

VS 151

666505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. 666505

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 525 Richwood Ave
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Richwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret F. Ries

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Andrew E. Ries | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1885

8. AGE: Years 63 | Months - | Days 3 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Patrick O'Hara
13. Birthplace Ireland

MOTHER 14. Maiden Name Annie Schenfer
15. Birthplace Maryland

16 (a) Informant Andrew E. Ries
(b) Address 525 Richwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3060 E. Balt. St.

19 SEP 3 1948 Huntington Williams M.D. (Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1st 1948, at 10 00 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 20, 1948, to Aug 31 1948.
and that I last saw h alive on 9/19

Immediate cause of death (1) Acute Congestive Heart Failure — Duration
Due to (2) Hypertrophy of the heart
Due to (3) Dropsy (Severe generalized swelling of the entire body.)
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Manuel Godard
Address 4624 York Road Date signed Sept 4 48

A 66506

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 9 21

Registered No. D66506

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Little Sisters of the Poor
(c) Hospital or institution:
Home for the Aged & Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Emma Carr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Edward Carr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1870

8. AGE: Years 78 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Alexander Gibson

13. Birthplace

MOTHER 14. Maiden Name Frances Walkins

15. Birthplace

16 (a) Informant Little Sisters of the Poor

(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1 '48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Pius Wiedefeld

(b) Address 900 E. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1948, at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1948, to Sept 2 1948, and that I last saw her alive on Sept 1 1948.

Immediate cause of death

Edema Lungs — Duration 1 day

Due to Chronic myocarditis — 3 yr

Due to

Other Conditions Arteriosclerosis — 10 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify in public place)
(e) Means of injury

23. Signature E Gill Hall M. D.

Address 103 E. Centre Ave Date signed Sept 2 48

VS 159

G66507

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

Registered No. G66507

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 2614
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 N. Kresson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE SHINE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: August

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1872

8. AGE: Years 76 | Months - | Days 23 | If less than one day: hr. min.

9. Birthplace: Baltimore County, Md. (Town, county, and state)

10. Usual Occupation: at home

11. Industry or business

FATHER
12. Name: Henry Wachsmuth
13. Birthplace: Baltimore County, Maryland

MOTHER
14. Maiden Name: Theresa Markel
15. Birthplace: Baltimore County, Maryland

16 (a) Informant: Mrs. Leach
(b) Address: West & Martel Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Carmel
Location: O'Donnell St.

18 (a) Funeral director: Clarence F. Woroner
(b) Address: 1639 N. Broadway

19 (a) SEP 3 - 1948 (Date received by Registrar) (b) Huntington Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1948, at 6:05 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: [signature] M.D. Medical Examiner
Date signed 9-3-48

VS 151

G666508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 666508

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 E. LAFAYETTE ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 E. Lafayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SENEY BELL DENNERT

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Andrew R. Dennert

6 (c) If alive, give age: 91 years

7. Birth date of deceased (mo., day, yr.): Sept. 12, 1861

8. AGE: Years: 86 | Months: 11 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name ? Rhinehardt
13. Birthplace unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Andrew R. Dennert
(b) Address 1807 E. Lafayette Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Md

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 3 - 1948 (Date rec'd by registrar) (b) Certificate for Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1940 to Sept 1948.
and that I last saw h[illegible] alive on Augt 31 1948.

Immediate cause of death — Duration

Chronic General Arteriosclerosis — Several Years

Due to Hypostatic Pneumonia — 3 Days

Due to Old age + ?

Other Conditions Infirmities 3 yrs Double Cataract - Blind

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Keown M.D.

Address 1938 Linden Ave Date signed 9/3/48

VS 150

G66509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66509

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5108 Ardmore Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5108 Ardmore Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN GERRIT KAMPS

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-07-7395

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna M. (Born) Kamps

6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Feb. 7, 1883

8. AGE: Years: 65 | Months: 6 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: Kraft Co.

FATHER
12. Name: Gerrit Kamps
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elsie Soth
15. Birthplace: Germany

16 (a) Informant: Mrs. Anna M. Kamps - widow
(b) Address: 5108 Ardmore Way - 6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/4/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) SEP 3 - 1948 (Date rec'd by registrar) (b) [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1948, at 7 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1948 to Sept 2 1948 and that I last saw him alive on Sept 2 1948.

Immediate cause of death: Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]

Address 5401 Belair Rd Date signed 9-2-48

6665 BC-40-17696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 666510

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette & Calhoun Sts.

(c) Hospital or institution: Franklin Sq Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d.

(e) Length of stay in Baltimore (yrs., mos., or days) 14 d.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1722 Johnson St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby boy Conway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/20/48

8. AGE: Years | Months | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas Conway

13. Birthplace Maryland

MOTHER 14. Maiden Name Lillian Kinsella

15. Birthplace Maryland

16 (a) Informant Thomas Conway

(b) Address 1722 Johnson St

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-4-48 (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Glen Burnie

18 (a) Funeral director James L. Tawney

(b) Address 130 E. Fayette St. Huntington Williams, Md.

19 (a) SEP 3- 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3rd 1948, at 6:20 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 8/20 1948, to 9/3 1948, and that I last saw him alive on 9/2 1948.

Immediate cause of death Respiratory failure

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Chas W. Christhilf M.D.

Address Franklin Sq. Hosp. Date signed 9/3/48

VS 159

G66511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1319

Registered No. G66511

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT WRITE IN SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 212 STONEY RUN LANE

(c) Hospital or institution: HILLCREST NURSING HOME

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 WKS.

(e) Length of stay in Baltimore (yrs., mos., or days) 61 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 503 BEAUMONT AVE. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME GEORGE SAMUEL LYLES

3 (b) If veteran, name war

3 (c) Social Security Account No 216-10-6701

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife MILLIE L. LYLES

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 4, 1873

8. AGE: Years	Months	Days	If less than one day
75	4	28	hr. min.

9. Birthplace CALVERT CO. MD. (Town, county, and state)

10. Usual Occupation BOOKKEEPER

11. Industry or business

FATHER 12. Name SAMUEL LYLES

13. Birthplace MD.

MOTHER 14. Maiden Name MARY LAWRENCE

15. Birthplace MD.

16 (a) Informant AUGUSTA LYLES

(b) Address 503 BEAUMONT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 4 48 (month) (day) (year)

(c) Cemetery or crematory MT. OLIVET

Location BALTO.

18 (a) Funeral director HENRY W. JENKINS & SONS

(b) Address 4905 YORK RD.

19 (a) SEP 3 - 1948 (b) Huntington Williams, M.D. Registrar

(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2nd 1948, at 5.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1946, to Sept 2 1948, and that I last saw him alive on Sept. 1 1948.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Arteriosclerotic Cardio-Renal disease with	
Due to uremia, terminal.	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Howland Edward Day

Address 4-E-33rd St Balto Date signed 9/3/48

VS 130

666512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666512

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 1519
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4124 Oak Hts. Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll Dolan (Nolan)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If [illegible] give age years

7. Birth date of deceased (mo., day, yr.) 9 - 1898

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Chicken Picker

11. Industry or business

FATHER
12. Name James Nolan
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace Md.

16 (a) Informant Mary Frots
(b) Address 2515 N. Bradle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location A. Holstead

18 (a) Funeral director Reid Hill
(b) Address 918 -

Date SEP 8 1948 (month) (day) (year) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1948 at 12 noon M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arterio sclerotic cardio Vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D.
Medical Examiner.
Date signed 8-29-48

G66513

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G66513 Registered No. 937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 W. Clement St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 W. Clement St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Tirsa

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife James M. Tirsa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) December 8

8. AGE: Years	Months	Days	If less than one day
? 78	9		hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business none

FATHER 12. Name Andrew Sayers
FATHER 13. Birthplace Germany
MOTHER 14. Maiden Name Theresa ? ?
MOTHER 15. Birthplace Germany

16 (a) Informant Mrs Edna M. Norton
(b) Address 109 W. Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Q. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 426 Light St.

19 (a) Date rec'd by registrar SEP 3 1948 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1948, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/31 1947 to 9/2 1948, and that I last saw h[illegible] alive on 9/2 1948.

Immediate cause of death Arteriosclerotic C. V. Disease — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Dreeson M. D.
Address 107 E. West St. Date signed 9/3/48

G66514

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. G66514

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 N. Bond St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Reynolds WASHINGTON

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-4103

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	C.	MARRIED

6 (b) Name of husband or wife ANNA ELIZABETH
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr) 3-18-1882

8. AGE: Years	Months	Days	If less than one day
66	5	14	hr. min.

9. Birthplace Richmond, VA
(Town, county, and state)
10. Usual Occupation PENSIONER
11. Industry or business

FATHER
12. Name ?
13. Birthplace VA.

MOTHER
14. Maiden Name CORNELIA WASHINGTON
15. Birthplace VA.

16 (a) Informant Robert WASHINGTON
(b) Address 817 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.
18 (a) Funeral director Robert L. Young
(b) Address 1216 N. Carolina St Baltimore, Md
19 (a) (Date received) SEP 6 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1948, at 9:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1948 to 9/1 1948
and that I last saw h(M) alive on 8/31 1948

Immediate cause of death cerebral hemorrhage — Duration 1 day
Due to hypertensive cardio-renal disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature RAYNER BROWNE, M.D.
Address 1500 EAST MADISON ST. BALTIMORE 5, MD.
Date signed 9/2/48

VS 150

G66515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G66515

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 Dolphin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 45 | Months | Days | If less than one day: hr. min.

9. Birthplace South Carolinia. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Jim Right

13. Birthplace S.C.

MOTHER 14. Maiden Name Ellen Right.

15. Birthplace N.C.

16 (a) Informant Eloise Logan Green

(b) Address 627 Dolphin St.

17 (a) [illegible] (b) Date thereof Sept. 6. 1948
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mount Calvery Com.
Location Green Wood.

18 (a) Funeral director Elroy O. Filson

(b) Address 1000 Brantly Ave.

19 (a) [illegible] 1948 (b) [illegible] Huntington Williams

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2, 1948. at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28, 1948. to Sept 2, 1948. and that I last saw him alive on Sept 1, 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 5 days.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature McDonald Bando M. D.

Address 2445 W. Hill Ave Date signed 9/2/48

G66516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121C

Registered No. 166516

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Edna Rhubottom

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Harry F Rhubottom
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1924

8. AGE: Years: 24 | Months: 3 | Days: 17 | If less than one day: hr. min.

9. Birthplace Sykesville Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Junkin F Coleman
13. Birthplace Md

MOTHER
14. Maiden Name Ella L. Houston
15. Birthplace Md

16 (a) Informant Harry F Rhubottom
(b) Address Sykesville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-48 (month) (day) (year)
(c) Cemetery or crematory West Liberty Cem
Location Alpha Md.

18 (a) Funeral director H. C. Heimbolkam
(b) Address Efficient Md

1948 SEP 3 (Date rec'd by registrar) (b) Huntingtor Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1, 1948, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31-48 19 . to 9-1-48 19 .
and that I last saw h[illegible] alive on 9-1-48 19 .

Immediate cause of death: Resp. failure — Duration

Due to Uremia

Due to Chronic glomerular nephritis & acute exacerbation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Whitte M. D.
Address University Hosp. Date signed 9-1-48

G66517
GM.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

Registered No. G66517

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 Minuts
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 N. Spring ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hazel Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race C
6 (a) Single, married, widowed, or divorced. S
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 29 1918
8. AGE: Years 30 Months - Days - If less than one day hr min.
9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Lorenzo Johnson
13. Birthplace MD.
MOTHER 14. Maiden Name Frances Garner
15. Birthplace MD.
16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3. 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery. Cem.
Location Brooklyn. Md.
18 (a) Funeral director Elroy. C. Wilson
(b) Address Brenly. Ave.
19 (a) SEP 3 - 1948 (Date rec'd by registrar) (b) Turtle Gate Mortuary, Inc.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 2- 19 48 at 9.40 M
21. I certify that death occurred on the date above stated, that I attended deceased from 9- 2- 19 48 to 9- 2- 19 48. and that I last saw her alive on 9- 2- 19 48
Immediate cause of death LOBAR PNEUMONIA LLL
a pleural effusion
Due to
Due to
Other Conditions PELVIC Inflammatory disease (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Lobar pneumonia LLL
Duration 5 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature David h. Maurer M. D.
Address Balto City Hosp Date signed 9-2-48
for C. J. Zubrod by H. J. Maeder M.D.

VS 150

To Be Approved By Medical Examiner

G666518

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G666518 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 North Durham Street
(c) Hospital or institution: – None – –
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 112 North Durham Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country – – –

3 (a) FULL NAME CARROLL T. HUMES

3 (b) If veteran, name war	3 (c) Social Security Account No.
?	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Mary Ann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/28/1879

8. AGE: Years	Months	Days	If less than one day
69	6	3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Box Factory

FATHER
12. Name John Humes
13. Birthplace England

MOTHER
14. Maiden Name Lucy ?
15. Birthplace Virginia

16 (a) Informant Ruth Trotta
(b) Address 112 North Durham Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/1948 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem.
Location Horners Lane

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 South Wolfe Street

19 SEP 3 - 1948 (Date rec'd by Registrar) Huntington Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 1948, at 6:45 A M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1948 to Sept 1 1948 and that I last saw him alive on Aug. 30 1948.

Immediate cause of death: Acute Cardiac Failure — Duration: 1½ hours
Due to Arteriosclerotic
Due to Heart Disease — 5 yrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Israel Kaen M.D. (M.D.)
Address 2413 E Monument St
Sept 2, 1948

VS 19

666519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666510

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Camp Holabird
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Maryland County
(c) City or town Baltimore
(Outside city limits write RURAL and give town)
(d) Street No. Camp Holabird
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ERNEST HIRSCH (Ernest R. Hirsch)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22. 1908

8. AGE: Years 40 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Mannheim Germany (Town, county, and state)

10. Usual Occupation Capt. U. S. Army

11. Industry or business

FATHER
12. Name Theodor Hirsch
13. Birthplace Unknown

MOTHER
14. Maiden Name Klara (Unknown)
15. Birthplace Unknown

16 (a) Informant U.S. Army Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9 4 48 (month, day, year)
(c) Cemetery or crematory Fermingdale National
Location Fermingdale L.I. N.Y.

18 (a) Funeral director Lilly and Zeller, Inc.
(b) Address 403 S. Wolfe St. Balto. 31.

19 (d) Date received by registrar SEP 3 - 1948 Huntington Williams, M.D.

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31/48 19 at 6:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Gun Shot Wound Head

Due to

Other Conditions Marked depressive State
(Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing [ ] cause of death, fill in the following.
(a) Date of injury 8/31 at approximately 6:50 P.M.
(b) Where did injury occur Camp Holabird
(c) Did injury occur at home, on farm, industrial place, in public place? Army Camp (While at work?) No
(d) Means of injury Self Inflicted 7.65 mm. Revolver

23. Signature John R Davis M.D.
Medical Examiner
Date signed 9/1/48

666520

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46E

Registered No. 666520

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton Ave & Edmondson
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 29 Bloomsbury Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Virginia Rappamier MRS. VIRGINIA M. RAPPAMIER
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Charles Rappamier
6 (c) If alive, give age 93 years

7. Birth date of deceased (mo., day, yr) Feb. 22, 1857

8. AGE: Years 91 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation domestic
11. Industry or business House wife

FATHER
12. Name Andrew Bassler
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Pfeifer
15. Birthplace Maryland

16 (a) Informant Frank O. Rappamier
(b) Address Catonsville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4 1947 (month) (day) (year)
(c) Cemetery or crematory St. John's
Location Howard Co.

18 (a) Funeral director Edward F. McNabb
(b) Address Catonsville Md

19 (a) SEP 3 - 1947 (Date rec'd by registrar) (b) Huntington Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1947 at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1947 to 9/1 1947 and that I last saw her alive on 9/1 1947.

Immediate cause of death CARDIO-RESPIRATORY FAILURE
Due to SENILITY
Due to CACHEXIA ARTERIO SCLEROSIS
Due to CARCINOMA OF CECUM
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clinton B. Hess M. D.
Address [illegible] Date signed 9/2

VS 199

G66521

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66521 Registered No. 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 W Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Frank Dale) FRED DOLES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 25

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Franklin Va (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name unknown
13. Birthplace " "

MOTHER 14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant James Coleman
(b) Address 1433 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-4-48 (month) (day) (year)
(c) Cemetery or crematory
Location Franklin Va

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave Winston-Salem N.C.

19 (a) (Date rec'd by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1948, at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted [illegible] accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Heat Stroke

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-28-48 at 9:00 P.M.
(b) Where did injury occur? 1433 W. Lombard St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Heat stroke

23. Signature C. P. Tulenko M.D. Medical Examiner.
Date signed 8/29/48

G666522

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46 B'

Registered No. G666522

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline St.
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Mr. William B. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) December 13, 1892

8. AGE: Years 55 | Months 8 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Self

FATHER
12. Name Harmon Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Black
15. Birthplace Md.

16 (a) Informant Irene Starka
(b) Address 1306 Green Mount Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (c) Date received SEP 4 1948 (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2, 1948 at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31, 1948 to Sept. 2, 1948, and that I last saw him alive on Sept. 2, 1948.

Immediate cause of death: Carcinoma of Stomach with metastasis to Liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Carcinoma of Stomach with metastasis to Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ray E. Pearson Jr.
Address St. Joseph's Hospital Signed 9/2/48

VS 150

G66523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66523 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1716 E. 31st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 E. 31st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Fadum

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-9704

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna G. Fadum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2nd 1883

8. AGE: Years: 64 | Months: 8 | Days: 11 | If less than one day: hr. min. 12

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business: Fadums Drug Store

FATHER 12. Name: Frederick Fadum

13. Birthplace: Germany

MOTHER 14. Maiden Name: Louise Albrecht

15. Birthplace: Md.

16 (a) Informant: Mrs. Anna G. Fadum

(b) Address: 1716 E. 31st St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof: Sept 4-48 (month) (day) (year)

(c) Cemetery or crematory: St Pauls Dulid Hill Park

Location: Druid Hill Park

18 (a) Funeral director: Williams Cook Inc

(b) Address: 217 St Paul St

19 (a) SEP 4 - 1948 (Date rec'd by registrar) Remington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2nd 1948, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 19 48 to Sept 2 19 48, and that I last saw him alive on Sept 1 19 48.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day

Due to: Arterio-Sclerosis - Chronic Nephritis → — 3 mos.

Due to: Nephritis - interstitial Chronic eg stenosis → — 1938 op.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Appendectomy Hadden, adhesions & Stones

of autopsy: Nephritis.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. N. Remington M.D.

Address 1520 E 33rd Date signed 9/3/48

G666524

1175651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G666524

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alphonsus Hasenkamp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1873

8. AGE: Years 75 | Months 7 | Days 21 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Anton Hasenkamp
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Baker
15. Birthplace Germany

16 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/4/48 (month) (day) (year)
(c) Cemetery or crematory Loved Ones
Location Pennington Hill Rd
18 (a) Funeral director Lloyd Baker & Sons
(b) Address 1368 Light St.

19 (a) SEP 4 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31- 19 48 7:25 A

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 19 42 to 8-31 19 48
and that I last saw h... alive on 8-31 19 48

Immediate cause of death: Bronchopneumonia — Duration: 2 days

Due to

Due to

Other Conditions: Arteriosclerotic Heart Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Rackold
Address Balto City Hosp. Date signed 9-7-48

VS 150

107

G666525 Mrs. S. Pamelia Kirwan

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G666525

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2404 St. Paul St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH PAMELIA KIRWAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Edgar F. Kirwan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 20, 1860

8. AGE: Years 87 | Months 9 | Days 12 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: George E. Greenwood
13. Birthplace: Kent Co.

MOTHER
14. Maiden Name: Martha C. Rutter
15. Birthplace: Cecil Co., Md.

16 (a) Informant: Mrs. Grace Breeden
(b) Address: 2404 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 4 - 1948 (Date rec'd by registrar) (b) Huntington Williamson, M.D.

VS 152

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2, 1948, at 11:10 M P

21. I certify that death occurred on the date above stated, that I attended deceased from June 1, 1947, to Sept. 2- 1948, and that I last saw h alive on Sept 2- 1948.

Immediate cause of death: Cardiac failure
Pulmonary edema.
Due to Cardio Vascular Renal disease
Due to Arteriosclerosis.

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration
15 mo
2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George E. Greenwood M. D.
Address 28 W 25th St. Date signed 9-3-48

G666526

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G666526 Registered No. 183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Pier #6 Pratt St.
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County Middlesex
(c) City or town Wake (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (djm) JOHN HENRY (GRINELL) GRINELS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lucy F. Grinels
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) June 3, 1885

8. AGE: Years	Months	Days	If less than one day
63	2 3		hr. min.

9. Birthplace Middlesex County, Va. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business self

FATHER
12. Name John Parker Grinels
13. Birthplace Middlesex County, Va.

MOTHER
14. Maiden Name Irene Harrow
15. Birthplace Middlesex County, Va.

16 (a) Informant William F. Grinels
(b) Address 613 Norwood Avenue Richmond, Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-5-48 (month) (day) (year)
(c) Cemetery or crematory Middlesex County, Va.
Location

18 (a) Funeral director Wm. J. Tuhman & Son
(b) Address 700 N. Avenue Ave.

19 (a) SEP 4 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1948, at 6:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found: 9-3-48 at 6:30 A M.
(b) Where did injury occur? Found: Pier #6--Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? No
(d) Means of injury Found drowned

23. Signature [signature] M.D. Medical Examiner.
Date signed 9-3-48

G66527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66527

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2312 Bryant Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 Bryant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Lipsitz

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Late Celia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1873

8. AGE: Years 75 | Months 74 | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Benjamin Lipsitz
(b) Address 2312 Bryant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 SEP 4 - 1948 Date rec'd by registrar Huntington Williams Registrar

VS 159

MEDICAL CERTIFICATION

10:50

20. DATE OF DEATH September 3 1948 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 21 1947 to Sept 3 1948 and that I last saw him alive on Sept 3, 1948.

Immediate cause of death	Duration
CARDIO - RESPIRATORY FAILURE	
Due to CEREBRAL HEMORRHAGE	
Due to HYPERTENSIVE CVH D. Generalized Arteriosclerosis	
Other Conditions DIABETES Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leland Carpenter M.D.
Address 2511 Reisterstown Rd Date signed 9/3/48

93

G66528
1223 44

18

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55c

Registered No. G66528

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Rochester Apts. 1E (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Liegel

3 (b) If veteran, name war: WORLD WAR I

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-27-94

8. AGE: Years 53 | Months 8 | Days 6 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER
12. Name Lazio Liegel
13. Birthplace Russia

MOTHER
14. Maiden Name Esther Leavitt
15. Birthplace Russia

16 (a) Informant Johns Hopkins Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5 1948 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-1126 N. North Ave

19 (a) SEP 4 - 1948 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

30

20. DATE OF DEATH Sept. 2 1948 at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29 1948 to Sept 2 1948 and that I last saw him alive on Sept. 2 1948

Immediate cause of death (1) Hemorrhage, meninges, interpulmonary, secondary to (2) Carcinoma of thyroid, c (3) peritracheal metastases — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman E. Freeman M. D.
Address Johns Hopkins Hospital Date signed 9-2-48

VS 150

G666529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G666529
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 Harford Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lake Ave., Rivera Beach
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES ALLEN LITCHFIELD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Viola R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1901

8. AGE: Years	Months	Days	If less than one day
47	7	25	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Painter
11. Industry or business (Self)

FATHER
12. Name William E. Litchfield
13. Birthplace Balto.

MOTHER
14. Maiden Name Virginia Roland
15. Birthplace Balto.

16 (a) Informant Mrs. Viola Litchfield
(b) Address 2309 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto. Md.

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd.

19 (a) SEP 4 - 1948 (Rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1948, at 3 PM

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil C. Ruzzo M.D.
Medical Examiner

Date signed Sept 4 1948

G66530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G66530

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4046 Hillen Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4046 Hillen Road
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Roben

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25.1859

8. AGE: Years	Months	Days	If less than one day
89	1	8	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Gerhardt Roben
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine
15. Birthplace Germany

16 (a) Informant MissAmelia Smith
(b) Address 4046 Hillen Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept.5/48 (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel Cem.
Location Balto. Md.

18 (a) Funeral director Charles Herwig Sons
(b) Address 2024 Orleans St.

19 SEP 4 - 1948 (Date rec'd by Registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept.3/48 19 . at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Sept-3-1948.
and that I last saw h alive on Sept-3-1948

Immediate cause of death — Duration

Cardio Vascular

Due to Arterio Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson White M. D.

Address 3005 St. Paul St., Date signed 9-4-48

VS 189

G66531 BC: F852x8 BALTIMORE CITY HEALTH DEPARTMENT 31 ✓ G66531

CERTIFICATE OF DEATH

18 6a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 853 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME MASTER - WALTER E. MATTHEWS. JR

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 21 st, 1943

8. AGE: Years 4 | Months 11 | Days 13 | If less than one day hr. min

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Walter E. Matthews
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary E. Sellers
15. Birthplace Baltimore Md.

16 (a) Informant Mr Walter E. Matthews
(b) Address 853 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location 3801 Frederick Ave

18 (a) Funeral director John J. Gowan & Son
(b) Address 901-03 Hollins St.

19 SEP 4 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Sept 48 1948. at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Sept 1948 to 3 Sept 1948. and that I last saw h/m alive on 3 Sept 1948.

Immediate cause of death Intraventricular hemorrhage — Duration 18 hrs.

Due to Head Trauma

Due to

Other Conditions Intracerebral hemorrhage — 8 hrs

(Include pregnancy within 3 months of death)

Date of operation 2 Sept 48

Major findings of operation: Intracerebral & intraventricular hemorrhage

Autopsy:

PHYSICIAN
Underline the cause to which it would be charged statistically.

22. If death was due to external causes, fill in the following 21/3
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 2 Sept. 48 at 3:30 P M
(c) Where did injury occur? 853 W.B. Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work? No
(e) Means of injury Fell in Yard

23. Signature Eduard N. Smith M D

Address University Hosp. Date signed 3 Sept 48

Baltimore Md. X

S. M. G. Helfrich, by Thomas T. Mellon, M.D.

VS 150

666532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

666532 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N. Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MUSGOE FAUNTLEROY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Fannie Fauntleroy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884.

8. AGE: Years 64 | Months | Days | If less than one day: hr. min

9. Birthplace Essex County, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Lawrence Fauntleroy

13. Birthplace Essex County, Va.

MOTHER 14. Maiden Name Emily

15. Birthplace Virginia

16 (a) Informant Norman Brown

(b) Address 228 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn.

Location

18 (a) Funeral director McKaig & Ellis

(b) Address 322 N. Schroeder St.

19 (a) SEP 4 1948 (Date received by Registrar) (b) Carrington Williamson (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep. 2, 1948, at 8:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection & Inquiry and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Carl L Royer M.D. (Medical Examiner)

Date signed 9 Sept 48

VS 151

G66533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 827 N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Odell Burton (Spell)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Jonny Spell | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-14-10

8. AGE: Years 38 | Months | Days 17 | If less than one day: hr. min.

9. Birthplace So. Carolina (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name A. Burton
13. Birthplace So. Carolina

MOTHER 14. Maiden Name Mamie Fuller
15. Birthplace So. Carolina

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 SEP 4 1948 (Date rec'd by local registrar) Registrar Washington Williams

VS 150

MEDICAL CERTIFICATION

45 A M

20. DATE OF DEATH September 1 1948, at 8

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1948, to 9/1 1948, and that I last saw her alive on 9/1 1948.

Immediate cause of death Uremia

Duration

Due to nephrosclerosis

Due to Essential Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)
Means of injury

23. Signature Sherman Mellnikoff
Address JOHNS HOPKINS HOSPITAL Date signed 9-6-48

G66534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

34 V 83a

Registered No. G66534

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 14
(e) Length of stay in Baltimore (yrs., mos., or days) 38

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 Brunt St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Greenwell
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1885

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Jim Greenwell
13. Birthplace md

MOTHER 14. Maiden Name Mary Summerville
15. Birthplace md

16 (a) Informant Elizabeth Green
(b) Address 1825 Brunt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-48 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location md

18 (a) Funeral director George R. Nelson
(b) Address 1302 Presstman St

19 (a) Received by registrar Huntington Williamsport

SEP 9

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1948, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22 1948 to 9-1 1948, and that I last saw him alive on 9-1-48 1948.

Immediate cause of death: Coronary thrombosis (Morbid conditions) — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Brophy M.D.
Address Provident Hosp Date signed 9-3-48

G66535

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66535

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1123 N. Longwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 N. Longwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY LOUISE REEDER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: John E. Reeder
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1, 1866
8. AGE: Years: 82 Months: 6 Days: 2 If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: George Wineke
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary Plunkett
15. Birthplace: Ireland

16 (a) Informant: Miss Nettie T. Reeder
(b) Address: 1123 N. Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 4 - 1948 (Date rec'd by registrar) (b) Huntington Ave. Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1948 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1947 to Sept 3 1948 and that I last saw her alive on Sept 2 1948

Immediate cause of death uraemia — Duration 2 days

Due to Chr. nephritis + — 2 years

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. J. McDermott
Address 1136 Poplar Grove St Date signed 9/3/48 M. D.

VS 150

G66536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH -13B

Registered No. G66536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 321 E. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 321 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** HAZEL C. RAPPAPORT

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Louis C. Rappaport

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): May 31, 1904

8. AGE: Years: 44 Months: 3 Days: 2 If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Michael E. Healy
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Katherine McAulliffe
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Zilda C. Glass, sister
(b) Address: 838 N. Augusta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)
(c) Cemetery or crematory: Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 4 - 1948 (Date rec'd by registrar) (b) Tuttington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1948, at 4:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1945 to Sept 3 1948. and that I last saw her alive on Aug 6 1948.

Immediate cause of death: Cardiac Failure — Duration:

Due to

Due to

Other Conditions: Pulmonary tuberculosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Jack J. Singer, M.D.
Address 5062 Northern Date signed 9-4-48

666537 HEALTH DEPARTMENT—CITY OF BALTIMORE 666537

CERTIFICATE OF DEATH

1. PLACE OF DEATH Crawford Retreat

CITY OF BALTIMORE: (No. 2117 Dennison St. 7-10 Ward)

Registered No. 927

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Albert H Bowen

If U.S. Veteran specify WAR

(a) Residence: No. 817 Beaumont Ave. St., ... Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) Nov. 1, 1875

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	10	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

FATHER

13. NAME Albert M. Bowen

14. BIRTHPLACE (city or town) (State or country) Balto., Md.

MOTHER

15. MAIDEN NAME Juliet Hewell

16. BIRTHPLACE (city or town) (State or country) Balto., Md.

17. INFORMANT (Address) Mr. Clarence Bowen 817 Beaumont Ave.

18. BURIAL, CREMATION, OR REMOVAL Place Woodlawn Cem. Date 9/6/48 19

19. UNDERTAKER (Address) M. J. TICKNER & SONS Balto., Md.

20. FILED SEP 4 - 1948 19... Registrar: Huntington for Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 3, 1948

22. I HEREBY CERTIFY, That I attended deceased from June 5, 1948, to Sept. 3, 1948

I last saw him alive on Sept 2, 1948. Death is said to have occurred on the date stated above, at 4 P m.

The principal cause of death and related causes of importance were as follows:

Myocardial Insufficiency — Date of onset 7-31-48

Hypertensive Cardiovascular Disease — Duration

Other contributory causes of importance:

Paralysis of left leg & Arm due to Cerebrovascular accident — 1948

Was an operation performed? No Date of

For what disease or injury?

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury ... 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) A Bradley Dewhurst M. D.

(Address) 1364 Francis Ave. Balto 27

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact OCCUPATION is very important. See instructions on back of certificate.

VR 3

G66538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55 B

Registered No. G66538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3315 Glenmore Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3315 Glenmore Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MILDRED GERMAN THEODORES

3 (b) If veteran, name war NO

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Nels H. Theodores

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1903

8. AGE: Years 45 | Months 5 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Baltimore Public School

FATHER
12. Name Wm. H. Davis
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Grace German
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Nels H. Theodores
(b) Address 3315 Glenmore Avenue

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9/6/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 4 - 1948 (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1948 at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 19 1946 to Sept 2 1948 and that I last saw h[illegible] alive on [illegible] 1948.

Immediate cause of death Carcinoma of Lumbo-Dorsal vertebrae — **Duration** 30 mo

Due to

Due to

Other Conditions Coronary thrombosis Acute

Acute general

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Luther E Leitch M. D.

Address 10 W. Madison St Date signed 9-3-48

VS 130

G66539 BC-148-14557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G66539 Registered No.

AB-122532 160c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20min.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3206 Tate St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Wimmy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 29-1948

8. AGE: Years | Months | Days | If less than one day: hr. 20 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Andrew Wimmy

13. Birthplace Ga.

MOTHER

14. Maiden Name Mabel Mason

15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8-31-48 At 9.00 A M (month) (day) (year)

(c) [redacted] crematory B.C.H.

Location 4940 Eastern Ave.

18 (a) Funeral director

(b) Address

19 SEP 4 - 1948 (Date rec'd by registrar) Turlington Williams, Agt

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29- 1948, at 3.10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-29- 1948 to 8-29 1948, and that I last saw her alive on 8-29- 1948

Immediate cause of death

Primary atelectasis immature

Spasm of Larynx

Due to Bronchus Contracted Pelvis

Duration 43 Mins

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Mid Fulpos Delivery

Major findings of operation:

of autopsy: [illegible] Abigail Kennedy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address 4940 Eastern Ave Date signed 8/31/48

VS 150

666540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

112

Registered No. 666540

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 39 N. Central Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew CHAMBERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	

6 (b) Name of husband or wife: Ardelia Chambers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1922

8. AGE: Years	Months	Days	If less than one day
26	7	6	hr. min.

9. Birthplace: Cleveland Co., N. C. (Town, county, and state)
10. Usual Occupation: Truck Driver
11. Industry or business: Wholesale Grocery

FATHER
12. Name: Rufus Chambers
13. Birthplace: York, South Carolina

MOTHER
14. Maiden Name: Lizzie Good
15. Birthplace: York, South Carolina

16 (a) Informant: Lizzie Chambers
(b) Address: Shelby, N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-48 (month) (day) (year)
(c) Cemetery or crematory: Ellis Chapel
Location: Shelby, N. C.

18 (a) Funeral director: Chas. R. Law
(b) Address: 802 Madison Ave

19 (a) SEP 4 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1948, at 12:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bronchial asthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: George G. Merrill M.D. Medical Examiner.
Date signed 9/9/48

G66541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66541 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 942 Stoddard Court
(c) Hospital or institution:

(d) Length of stay in hospital or ins. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 942 Stoddard Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES CURTIS JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mary Deborah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1886

8. AGE: Years	Months	Days	If less than one day
62	3	1	hr. min.

9. Birthplace Long Green, Maryland.
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name James W. Jones
13. Birthplace Maryland.

MOTHER
14. Maiden Name Eliza Quickley
15. Birthplace Maryland.

16 (a) Informant Mrs. Mary D. Jones
(b) Address 942 Stoddard Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore Co. Maryland.

18 (a) Funeral director Thos. George H. Shellman
(b) Address 1691 Druid Hill Ave.

19 (a) Filed SEP 8 1948 (b) Registrar Washington Williams, Jr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2/1948, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/22 1948 to 9/3 1948 and that I last saw h[im] alive on 9/2 1948.

Immediate cause of death Intestinal Carcinoma (Colon)
Due to
Due to
Other Conditions
(include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

Duration: 8-10 mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Proctor Grant M. D.
Address 6101 N. Carroll Ave. Date signed 9/2/48

G66542

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G66542

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 431 South Robinson Street
(c) Hospital or institution: — — None — — —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 431 South Robinson Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME MARY ROMANSKI

3 (b) If veteran, name war None

3 (c) Social Security Account No. ?

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Francis Romanski

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 11/15/1873

8. AGE: Years 74 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER
12. Name John Bialozenski
13. Birthplace ?

MOTHER
14. Maiden Name Josephine ?
15. Birthplace ?

16 (a) Informant Bernard Romanski
(b) Address 431 South Robinson Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9/6/1948 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem.
Location Dundalk Avenue

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 1901 Eastern Avenue Balto. 31

19 (a) (Date received) SEP 4 - 1948 (Registrar) Huntington McManus Jr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3, 1948, at 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1948 to Sept 3 1948 and that I last saw h[illegible] alive on Sept 3 1948

Immediate cause of death Coronary Thrombosis — Duration 2 hrs.

Due to previous attack of Coronary Thrombosis — 3 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or Homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. J. Davidow M. D.

Address 3218 Eastern Ave Date signed 9-4-48

G66543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G66543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2534 Mc Cullob St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2534 Mc Cullob St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Viola J. Phillips

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James Phillips

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Oct 27, 1900

8. AGE: Years 47 | Months 10 | Days 5-6 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Irvin Perry
13. Birthplace Balto Md

MOTHER
14. Maiden Name Lila Morris
15. Birthplace Balto Md

16 (a) Informant James Phillips
(b) Address 2534 Mc Cullob St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/48 (Month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem Co
Location A A Co Md

18 (a) Funeral director Isaiah A Brandon
(b) Address 1846 Montgomery St

19 (a) Date received SEP 4 1948 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1948, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1948 to Sept 2 1948, and that I last saw her alive on Sept 2 1948.

Immediate cause of death Carcinoma of Breast — Duration 2 yrs

Due to Metastases — 1 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Frey M. D.
Address 1928 Penna Ave Date signed 9/7/48

G66544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G66544
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4514 Dunbar St.
(c) Hospital or institution: Provident Hosp
Baltimore Md
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Charles
(c) City or town Waldorf
(If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Nettie Butler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 79 Months 3 Days 22 If less than one day hr. min.

9. Birthplace Charles Co. Md. (Town, county, and state)

10. Usual Occupation Farming
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Nettie Butler
(b) Address Waldorf, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)
(c) Cemetery or crematory Waldorf, Md.
Location

18 (a) Funeral director Hunt & Heyn
(b) Address Waldorf, Md.

SEP 9 1948 (Date filed by registrar)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4-1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3-48 to 9-4-1948 and that I last saw deceased alive on 9-4-1948

Immediate cause of death (a) Pulmonary edema (Edema Pulmonale)

Due to (b) Coronary Occlusion

Due to (c)

Other Conditions

(Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature [illegible] M. D.
Address Waldorf, Md. Date signed

PHYSICIAN
Underline the cause to which death should be charged statistically.

G66545

412677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66545 Registered No.

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky. (b) County
(c) City or town HARLAN, (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sidney BARNES Douglass

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: BRUNWEN — ?
6 (c) If alive, give age ?years

7. Birth date of deceased (mo., day, yr.) NOV. 16 1884

8. AGE: Years 63 | Months 9 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Ky (Town, county, and state)

10. Usual Occupation Manager Wholesale -
11. Industry or business Grocery

FATHER 12. Name Jesse Douglas
13. Birthplace Ky

MOTHER 14. Maiden Name Florence [illegible]
15. Birthplace Ky

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 4 '48 (month) (day) (year)
(c) Cemetery or crematory REST HAVEN
Location HARLAN KENTUCKY

18 (a) Funeral director Henry H Wiltse
(b) Address 410 Edmondson Ave

SEP 6 - 1948 (Date rec'd by reg.) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 4 - 1948 at 1.25 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 19 to 19 and that I last saw him alive on 9-4 1948.

Immediate cause of death: Intracerebral hemorrhage, left

Due to Parkinsonian syndrome, type undetermined

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Norman C Shaver M D
Address JOHNS HOPKINS HOSPITAL Date signed 9-7-48

G66546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 952

Registered No. G66546

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1530 Northgate Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town).
(d) Street No. 1530 Northgate Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roberta Aloyse Litz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1894

8. AGE: Years	Months	Days	If less than one day
54	2	23	26 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Henry G. Litz
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Loretta A. Foige
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Gordon P. Litz
(b) Address 1530 Northgate Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Md.

18 (a) Funeral director Charles Lamoreau
(b) Address 4510 Liberty Heights Ave.

19 (a) (b)

SEP 8 1948

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 3rd 1948, at 7:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 1st 1948 to SEPT. 3rd 1948, and that I last saw h[illegible] alive on SEPT. 1st 1948.

Immediate cause of death PUMONARY EDEMA — Duration 1 hour

Due to CONGESTIVE HEART FAILURE — Duration SEVERAL MONTHS

Due to CHR. RHEUMATIC HEART DISEASE — Duration MANY YEARS

Other Conditions NONE

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ferdinand E. Chatard, M. D.
Address 1300 N. Calvert St., Balto. 2, Date signed 9-3-48

G66547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66547 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Liberty Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SALLY LEWIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Nathan D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Not Known
13. Birthplace Poland

MOTHER 14. Maiden Name Not Known
15. Birthplace Poland

16 (a) Informant Dr. J. W. Lewis
(b) Address 3300 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship Cem
Location

18 (a) Funeral director Jack Lewis Inc.
(b) Address 2120 Eutaw Place

19 (a) SEP 5 1948 (Date rec'd by registrar) (b) Burlington-Washington Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3 1948, at 10:

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1948 to Sept 3 1948, and that I last saw her alive on 9-3 1948.

Immediate cause of death: Pulmonary Embolism — Duration

Due to Arteriosclerotic H.D

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Katz
Address Sinai Hosp Date signed 9-3-48

VS 180

G66548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G66548 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1740 E Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1740 E Chase St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Jessie M. Deffinbaugh (Oeffenbaugh)

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-22-5265

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F M	W	Widowed

6 (b) Name of husband or wife Geo. Wolfmeyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-30-1867

8. AGE: Years	Months	Days	If less than one day
81	7	—	hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jessie Deffinbaugh

13. Birthplace Sand Z Sligo

MOTHER 14. Maiden Name Penna

15. Birthplace

16 (a) Informant John Deffinbaugh

(b) Address 1740 E Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-45 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto Md

18 (a) Funeral director Leonard Bond

(b) Address 3857 Harford Rd

19 (a) (Date) 1945 registrar Huntington Williams M.D.

SEP 5

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1945 at 1 P M

21. I certify that death occurred on the date above stated, that I attended deceased from June 19 42 to Sept 2 1945.

and that I last saw h[illegible] alive on Sept 1 1945.

Immediate cause of death Cachexia from Metastatic Carcinoma

Duration 2 yrs

Due to Carcinoma of Colon

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Leonard Bond M. D.

Address 2211 Eager Ave Date signed Sept 3, 1945

G66549

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 96

G66549
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Wis. (b) County
(c) City or town Racine (If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 N. Chathan St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gunnet Jensen

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex Male | **5. Color or race** White | **6 (a) Single, married, widowed, or divorced.** married

6 (b) Name of husband or wife Elizabeth Jensen
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 4-5-99

8. AGE: Years 49yrs | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Denmark (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Marinus Jensen
13. Birthplace Denmark

MOTHER 14. Maiden Name Pengto Person
15. Birthplace Sweeden

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Mound Cem (Burial, cremation, or removal) (b) Date thereof Sept 6/48 (month) (day) (year)
(c) Cemetery or crematory Mound Cem
Location Racine Wis

18 (a) Funeral director Uelmen Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date received by registrar) (b) Registrar's signature

SEP 8 1948

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 4 - 1948 at 5 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1948 to Sept 4 1948.
and that I last saw him alive on Sept 2 1948.

Immediate cause of death	Duration
Ruptured aneurysm Circle of Willis	
Due to Cerebral	
Due to Congested	
Other Conditions	

(include pregnancy within three months of death)

Date of operation Sept 3 1948

Major findings of operation: Bleeding aneurysm

of autopsy: Ruptured aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature M. D.
Address JOHNS HOPKINS HOSPITAL Date signed Sept 8

G66550

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92a

G66550 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 S. Milton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 S. Milton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Poland

3 (a) FULL NAME Maryanna Spioch

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George Spioch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1868

8. AGE: Years: 80 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Poland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Poland

16 (a) Informant: Mrs. Gerwazzia Spioch
(b) Address: 509 S. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sep 6 1948 (month) (day) (year)
(c) Cemetery or crematory: Holy Rosary Cem
Location: Baltimore County

18 (a) Funeral director: John M. Weber
(b) Address: 401 S. Chester Street

19 (a) [illegible] 1948 (Registrar) (b) [illegible]

MEDICAL CERTIFICATION

820

20. DATE OF DEATH: Sep 3 1948, at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 18 June 1948 to 3 Sep 1948, and that I last saw her alive on 1 Sep. 1948

Immediate cause of death	Duration
Cardiac failure	2 da.
Due to Cardiac hypertrophy & dilatation	1 mo.
Due to Arteriosclerotic C-V disease	
Other Conditions Aortic stenosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Joseph Drozd
Address 2601 Eastern Ave. Date signed 3 Sep. 48 M. D.

G66551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

G66551 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 S. Vincent St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Edward Kell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Florence Barr Kell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 20, 1928 ?

8. AGE: Years 27 | Months 0 | Days 6 | If less than one day 13 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Truck driver

11. Industry or business

FATHER
12. Name Truman Kell
13. Birthplace Baltimore

MOTHER
14. Maiden Name May Kell
15. Birthplace Unknown

16 (a) Informant Florence Barr Kell
(b) Address 505 S. Vincent St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-48 (month, day, year)
(c) Cemetery or crematory Mt. Olivet Cem
Location Frederick Ave

18 (a) Funeral director Edward Toulson
(b) Address 2319 Gwynn Oak Blvd

19 (a) SEP 3 1948 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1948, at 4:15 PM

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to illuminating gas

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 3/48 Approx. 3:30 P.M.
(b) Where did injury occur? 505 S. Vincent St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Gas hose in mouth

23. Signature Edward L. Royer M.D.
Medical Examiner
Date signed 9/4/48

VS 181

G66552

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66552 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 56 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County Pr. Geo.
(c) City or town Bowie
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Richard Hawkins

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex M | **5. Color or race** C | **6 (a) Single, married, widowed, or divorced.**

6 (b) Name of husband or wife Ethel Hawkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1884

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Pr. Geo Co Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business Laborer

MOTHER FATHER
12. Name Richard Hawkins
13. Birthplace Pr. Geo Co Md
14. Maiden Name Rachel Higgs
15. Birthplace Pr Geo Md

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8 45 (month) (day) (year)
(c) Cemetery or crematory Ascension
Location Bowie Md

18 (a) Funeral director Martin Hodnett
(b) Address Bowie Md

5 (a) 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1945 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1944, to Sept 4 1945, and that I last saw him alive on Sept 1945.

Immediate cause of death Coronary Occlusion Hydrocephalus
COMMUNICATING HYDROCEPHALUS

	Duration
Due to Cerebral Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 9/4/45

G66553

A 6497 64

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66553 1236

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MAINE. (b) County
(c) City or town STARKS, (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D.Y. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Janet Gayle Hall.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-22-43

8. AGE: Years	Months	Days	If less than one day
4 5	11	13	hr. min.

9. Birthplace Maine (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Albert Hall
13. Birthplace Ky.

MOTHER 14. Maiden Name Eleanor Preston
15. Birthplace Ky.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 5/48 (month) (day) (year)
(c) Cemetery or crematory Ashland Ky
Location same

18 (a) Funeral director Wilhelm Funeral Home
(b) Address 2008 Orleans St

19 (a) (Signature of Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 5 - 1948, at 12 4½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22- 1948 to 9-5 1948 and that I last saw her alive on 9-5- 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Uremia	3 wks
Due to Renal Insufficiency	5 yrs
Other Conditions Renal rickets, Renal Rickets	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harrison Clark Spencer M. D.

Address JOHNS HOPKINS HOSPITAL Date signed 9-5-48

G66554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G66554 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct address especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Woman's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Lexington St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Rose E. L. King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband Richard N. King

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-26-64

8. AGE: Years 84 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Henry Sumwalt

13. Birthplace

MOTHER 14. Maiden Name Martha Mules

15. Birthplace

16 (a) Informant W. W. Hoopes

(b) Address 1715 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)

(c) Cemetery Green Mount

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St

19 (a) (b) Registrar

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1948 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29 1948 to Sept. 3 1948 and that I last saw her alive on Sept. 3 1948.

Immediate cause of death

Duration

Heat Exhaustion

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

~~Major findings of operation~~: generalized Arteriosclerosis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry H. Lattimore M. D.

Address Harve Town Md. Date signed Sept. 3 48

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G66555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G66555
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct spelling especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 636 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 636 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie K. Stevenson ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband or wife John Stevenson
6 (c) If alive, give age years

7 Birth date of deceased (mo., day, yr.) Sept 8th 1870

8. AGE: Years	Months	Days	If less than one day
77	11	25	hr. min.

9. Birthplace Ayr, Scotland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Archibald King
13. Birthplace Scotland

MOTHER
14. Maiden Name Margaret Pollock
15 Birthplace Scotland

16 (a) Informant Elizabeth Coates
(b) Address 636 W. North Ave

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 4/6/48 (month) (day) (year)
(c) ~~Cemetery or crematory~~ Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

SEP 6 - 1948
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3rd 1948, at 8 45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1948 to Sept. 3 1948 and that I last saw her alive on Sept. 3 1948

Immediate cause of death	Duration
Bronchopneumonia	4 days
Due to Cerebral Hemorrhage	6 (6) hrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clark H. Bowman M.D.
Address 5111 York Rd Date Sept. 4, 1948

G66556

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 123

G66556
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3417 HAMILTON Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. UNITY ELIZABETH AARON DORRELL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, (widowed) or divorced.
F	White	

6 (b) Name of husband or wife DECEASED

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/23/1868

8. AGE: Years	Months	Days	If less than one day
79	9	11	hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name John Thomas AARON
13. Birthplace MARYLAND

MOTHER
14. Maiden Name Mary ELIZABETH McGRAW
15. Birthplace MARYLAND

16 (a) Informant DAUGHTER (Mrs Helen MANN
(b) Address 3417 HAMILTON Ave, BALT, MD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)

(c) Cemetery or crematory Balto. Md.
Location

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

Filed SEP 8 1948
Received by registrar Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1948 at 9 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30 1948 to Sept 3 1948, and that I last saw h e alive on Sept 3 1948.

Immediate cause of death PULMONARY Edema

Due to CARDIAC FAILURE

Due to ARTERIOSCLEROTIC HEART DISEASE

Other Conditions 2 days post op for perforated Sigmoid diverticulum (Include pregnancy within 3 months of death)

Date of operation Aug. 30, 1948

Major findings of operation: Generalized peritonitis from perforated diverticulum

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Dalton E. Clemens M. D.
Address Union Memorial Hospital Date signed 9/3/48

Copied by [illegible]

X

G66557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G66557 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring Ave
(c) Hospital or institution: Levindale Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 W. Garrison Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE SOBER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband ~~or wife~~ Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation —

11. Industry or business Housewife

FATHER
12. Name Samuel Solomon
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Russia

16 (a) Informant Nathan Sober
(b) Address 3610 W. Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 6 48 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cong
Location Southern avenue

18 (a) Funeral director Sol Levinson & Bro
(b) Address 112-26 W. North Avenue

19 (a) (Filed by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5 1948 at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28 1948 to 9-5 1948 and that I last saw her alive on 9-5 1948

Immediate cause of death Cerebral hemorrhage — Duration

Due to arteriosclerosis

Due to Diabetes mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Home Date signed 9-5-48

VS 150

G666558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G666558 112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland ✓

(b) Street address 6420 Reisterstown Road

(c) Hospital or institution: The Seton Institute

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-28

(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)

(d) Street No. 3609 Clarinth Rd, Balto. 15 (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Samuel Geltman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of ~~husband or~~ wife: Evelyn R. Royppen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-27-1906

8. AGE: Years 42 | Months 5 | Days 5 | If less than one day: hr. min.

9. Birthplace Memphis, Tennessee (Town, county, and state)

10. Usual Occupation Service Station Operator

11. Industry or business

FATHER — 12. Name Abraham Geltman

13. Birthplace Russia

MOTHER — 14. Maiden Name Mary Frieman

15. Birthplace Russia

16 (a) Informant The Seton Institute

(b) Address 6420 Reisterstown Rd., Balto 15, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-48 (month) (day) (year)

(c) Cemetery or crematory United Hebrew

Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc

(b) Address 200 Eutaw Place, Baltimore, Md.

SEP 6 1948 (State registrar)

Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5 1948 at 8/11 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1948 to 9/5 1948 and that I last saw h~~im~~ alive on 9/5 1948

Immediate cause of death: Cardio-Respiratory Failure — Duration: —

Due to Bronchial Asthma — Duration: 24 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Irwin Cohen M.D.

Address Seton Institute Date signed 9/5/48 M D

666559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

666559 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 do Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LENA ISAACSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1873

8. AGE: Years 75 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER OF PATIENT
12. Name Deceased
13. Birthplace Russia

FATHER OF PATIENT
14. Maiden Name Kurzak
15. Birthplace Russia

16 (a) Informant Abraham Isaacson
(b) Address 11 do Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Perkins Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 3100 Eastern Place

19 (a) 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1948 at abt 10 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from DOA to 19 , and that I last saw h alive on 19 .

Immediate cause of death Myocardial Insufficiency — Duration

Due to Arteriosclerotic Heart Disease

Due to Poss Rheumatic HD

Other Conditions Pulmonary Edema + Congestion

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Judith Landau M.D.
Address Sinai Hosp Date signed 9/5/48 M. D.

VS 150

G66560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. G66560

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3557 THIRD STREET (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OTTO W. SCHOMAKER (Otto W. Schomaker)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Katherine E. Schomaker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 16, 1890

8. AGE: Years	Months	Days	If less than one day
58	5	19	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Stevedore Foreman
11. Industry or business

FATHER
12. Name John Schomaker
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Scholle
15. Birthplace Germany

16 (a) Informant Mrs. Otto W. Schomaker
(b) Address 3557 Third St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lennahan Funeral Home
(b) Address 7101 Belair Rd.

19 (a) (Date rec'd by registrar) (Registrar)

SEP 8 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1948 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1948 to 9/5 1948, and that I last saw h[im] alive on 9/5 1948

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 6 days

Due to PREFRONTAL LOBOTOMY FOR INTRACTABLE PAIN

Due to CANCER of BLADDER

Other Conditions Uremia & Debility due Cancer of bladder

(Include pregnancy within 3 months of death)

Date of operation 8/30/48 & 9/4/48

Major findings of operation: Edema, brain, lungs, genital organs

Findings of autopsy: Arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Lennahan M.D.
Address Sinai Hospital Date signed 9/7/48

G66561

BALTIMORE [redacted] LTH DEPARTMENT

CERTIFICATE OF DEATH 166

G66561
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 860 W. Fairmount Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (PARRELL PEARSON) PONIER GUNTHROP PEARSON (d.m)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1933

8. AGE: Years	Months	Days	If less than one day
14	10	25	hr. min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation Attended School

11. Industry or business

FATHER 12. Name Deming Pearson
13. Birthplace S. C.

MOTHER 14. Maiden Name Lergenia Gunthrop
15. Birthplace S. C.

16 (a) Informant Lergenia Pearson
(b) Address 860 W. Fairmount Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-6-48
(months) (days) (years)

(c) Cemetery or crematory
Location Mt. Calvary Baltimore

18 (a) Funeral director A. Balitzer
(b) Address 918 Druid Hill

SEP 6 1948 [redacted] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 19 48 at 9:25 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bullet-wound of right kidney.

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-1-48 at Approx. 8:30 A M.
(b) Where did injury occur? [redacted] W. Lombard St.
(c) Did injury occur at home, on farm, industrial place, in public place? a home While at work? No
(d) Means of injury Firearms

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9-1-48

G66562

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. G66562

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 W. Belvedere Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Tom Wilson

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 02-451-011

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Father Mac Wilson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Jan 28, 1887

8. AGE: Years	Months	Days	If less than one day
61	7	6	— hr. — min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Chief Engineer
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Walter J. Wilson
13. Birthplace England

MOTHER
14. Maiden Name Annie Sands
15. Birthplace England

16 (a) Informant (Patient's administrator)
(b) Address —

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)
(c) Cemetery or crematory Woodmere
Location Huntington, W. Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 6 1948
Date rec'd by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1948, at 1:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1948, to Sept. 4 1948, and that I last saw him alive on Sept. 4 1948.

Immediate cause of death	Duration
Uremia	
Due to Congestive heart failure	
Due to ASHD	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: A.S. [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify) While at work?
(e) Means of injury

23. Signature Glenn P. Grove
Address Union Memorial Hosp Date signed 9/6/48 M. D.

92

Please write plainly, with INDELIBLE INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G66563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County Washington
(c) City or town Pelham Manor Gardens (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country (Yes or No) If yes, name country

3 (a) FULL NAME JOHN J. DONAHUE

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 060-05-1690

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed.
6 (b) Name of husband or wife: Eglae L. Donahue
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr): APRIL 10, 1880
8. AGE: Years 68 | Months 4 | Days 25 | If less than one day hr. min.
9. Birthplace: New York (Town, county, and state)
10. Usual Occupation: Salesman
11. Industry or business

FATHER
12. Name: BERNARD DONAHUE
13. Birthplace: New York

MOTHER
14. Maiden Name: MARY MANNING
15. Birthplace: Manchester, England

16 (a) Informant
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Sepulcher Cem.
Location: New Rochelle, N.Y.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 6 1948 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1948 at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1948 to Sept 5 1948.
and that I last saw him alive on Sept. 5 1948.

Immediate cause of death: Cerebral Vascular Accident — Duration: +10 yrs.
Due to: Hypertensive and Arteriosclerotic heart disease
Due to disease
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. W. Smith
Address JOHNS HOPKINS HOSPITAL Date signed 9/5/48

G66564 ✓ G66564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2430 W. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edna M, Jones (Edna Muriel Jones)

3 (b) If veteran, name war: - no
3 (c) Social Security Account No.: - no

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: William P. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1894

8. AGE: Years 53 | Months 10 | Days 22 | If less than one day: hr. min.

9. Birthplace Parsons, W. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lloyd W. Warner
13. Birthplace W. Va.

MOTHER
14. Maiden Name Cora Carrico
15. Birthplace W. Va.

16 (a) Informant Mr. William P. Jones
(b) Address 2430 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location Woodlawn, Maryland

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1948. at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1947 to Sept 3 1948. and that I last saw h[illegible] alive on Aug 25 1948.

Immediate cause of death Carcinomatosis — Duration

Due to Papillary Adenocarcinoma of ovary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec 1947

Major findings of operation: Ca of ovary Post-radiation Hernia

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis E Goodman M. D.
Address 1211 Eutaw Pl Date signed 9/3/48

G66565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G66565 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5506 South Bend Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5506 South Bend Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: HANNAH R. RUDDOCK

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Thomas Herbert Ruddock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 26, 1861

8. AGE: Years 87 | Months 5 | Days 7 | If less than one day: hr. min.

9. Birthplace: Gaithersburg, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: George Enoch Noyes
13. Birthplace: England

MOTHER
14. Maiden Name: Suzanna Davis
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. William W. Werking
(b) Address: 5506 South Bend Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location: Washington, D. C.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: North & Pa. Aves.

19 (a) (Date rec'd by registrar)

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 3, 1948, at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1948 to 9/3 1948 and that I last saw h[illegible] alive on 9/3 1948.

Immediate cause of death: Coronary occlusion — Duration: 2-3 hrs

Due to

Due to Pulmonary

Other Conditions: Syphilitic aneurism of left Pulmonary artery

(Include pregnancy within 3 months of death)

Date of operation: no

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address 3902 Kenelworth Date signed 9/4/48

G66566

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

8 3a

G66566
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 W. Hamburg (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhemena Lopez — Willie Lopez

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Negro	Married

6 (b) Name of husband or wife Archie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1867

8. AGE: Years 61 | Months | Days | If less than one day: hr. min.

9. Birthplace Ala. (Town, county, and state)

10. Usual Occupation Dressmaker

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name Fannie Thomas
15. Birthplace Ala.

16 (a) Informant Archie Gleaves
(b) Address 635 Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 6-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date received by registrar) (b) Registrar's signature

SEP 8 - 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1948; at 12 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31 1948 to 9-2 1948 and that I last saw her alive on 9-2 1948

Immediate cause of death Cerebral vascular accident

Due to Hypertension

Due to

Other Conditions Pontine Neuralgia (Include pregnancy within 3 months of death)

Duration: 1

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. E. Bradyle
Address Provident Hosp Date signed 9-2-48

Dr Hawkins

666567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 666567

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 424. w. Biddle. St.

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)

(d) Street No. 424. w. Biddle. St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William. H. Griggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. June. 18. 1910

8. AGE:

Years	Months	Days	If less than one day
37	2	16	hr. min.

9. Birthplace Farmsville, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name Williams. Griggs

13. Birthplace Farmsville. Va.

MOTHER

14. Maiden Name Georgania. Griggs

15. Birthplace Farmsville. Va.

16 (a) Informant Mrs. Fannie. Watkins

(b) Address 425. N. Wolfe. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9. 1948 (month) (day) (year)

(c) Cemetery or crematory Green. Creek. Cem.

Location Cumberland, Co. Va.

18 (a) Funeral director Elroy. O. Wilson

(b) Address 1000. Brantly. Ave.

19 (a) (b) Registrar

Filed by registrar SEP 6 - 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4/ 1948 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/ 1948 to 9/4/ 1948 and that I last saw him alive on 9/4/ 1948

Immediate cause of death

Lobar Pneumonia

Duration 8 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address 450 W. Biddle St. Date signed 9/6/48

BC-KP-6802 Beckner 666568

666568

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 157E

PRESS WHITE PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days (Ck)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Towson #4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 E. Joppa Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Kenneth William Beckner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 25, 1948

8. AGE: Years | Months | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Elroy Beckner
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Elsie Kiplinger
15 Birthplace Balto.

16 (a) Informant Elmer Beckner
(b) Address 1915 E Joppa Rd. 9-6-48

17 (a) B. (Burial, cremation, or removal) (b) Date filed (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location GLEN BURNIE

18 (a) Funeral director J. F. McCaney
(b) Address 136 E. Fayette St. Attn: Mr. Williams

19 (a) SEP 6 1948 (b) (Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1948, at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 1948 to Sept. 4 1948, and that I last saw h[illegible] alive on Sept. 4 1948.

Immediate cause of death Congenital Heart Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Patent Ductus Arteriosus

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) while at work?
(e) Means of injury

23. Signature Robert E. Lenson M.D.
Address Mercy Hospital Date signed 9/4/48

G66569

BALTIMORE CITY HEALTH DEPARTMENT Sauers

CERTIFICATE OF DEATH

G66569 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 175 W. Cromwell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Sauers Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 15-1879

8. AGE: Years 68 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER 12. Name Martin Sauers

13. Birthplace Md.

MOTHER 14. Maiden Name Josephine ?

15. Birthplace Md.

16 (a) Informant John Sauers Jr. Son

(b) Address 1823 Covington St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)

(c) Cemetery or crematory PEARL HILL

Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DEVINE, INC.

(b) Address 715 LIGHT ST

SEP 8 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1948 to 9/3 1948 and that I last saw him alive on 9/3 1948

Immediate cause of death: Anuria — Duration

Due to Urinary Obstruction

Due to Carcinoma of the Prostate

Other Conditions Uremic Hydronephrosis

(Important pregnancy within 3 months of death)

Date of operation 8/25/48

Major findings of operation: Acute Hydronephrosis

of autopsy: Ca of Prostate

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.

Address Franklin Sq. Hosp. Date signed 9/3/48

VS 150

Please write plainly, with pen and ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66570

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 51 B

G66570
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1109 HAUBERT ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 HAUBERT ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARL EARNEST JUPITZ

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-01-6360

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife ANNA MARIA (WILFE)
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr) NOV 7, 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER	12. Name	UNKNOWN
	13. Birthplace	"
MOTHER	14. Maiden Name	"
	15. Birthplace	"

16 (a) Informant MR FRED JUPITZ
(b) Address 1109 HAUBERT ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 8 48 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN E. PETERMAN, INC
(b) Address 715 LIGHT ST. -30

19 SEP 6 1948 Registrar Washington Millington

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 4, 1948; at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from APR. 25, 1947; to SEPT. 4 1948. and that I last saw him alive on AUG. 27 1948.

Immediate cause of death Carcinoma of Prostate Gland with metastasis to Liver — Duration 1½ yrs
Due to
Due to
Other Conditions Arteriosclerotic hypertensive heart disease
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: Inoperable
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James E. Peterman M. D.
Address 1226 Hanover St Date signed 9-4-48

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G66571

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 HANOVER ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 HANOVER ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DIETRICH A. N. ELLERMANN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife ANNIE HEINLEIN
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr) JULY 1, 1875

8. AGE: Years	Months	Days	If less than one day hr.	min.
72				

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation FARMER
11. Industry or business

FATHER
12. Name FRANK ELLERMANN
13. Birthplace GERMANY

MOTHER
14. Maiden Name LOUISE ELLERMANN
15. Birthplace ~~Germany~~

16 (a) Informant MRS ANNIE ELLERMAN
(b) Address 1601 HANOVER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 7 48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location WOODLAWN, MD

18 (a) Funeral director JOHN F. DENNELLY
(b) Address 715 LIGHT ST - 30

SEP 6 - 1948 (Date rec'd by registrar)

(a) (b) Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1948 at 3 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from July 2 1948 to Sept 3 1948, and that I last saw him alive on Sept 3 1948.

Immediate cause of death: Myocardial insufficiency — Duration

Due to

Due to

Other Conditions: Hypertension. Arteriosclerosis.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work
(e) Means of injury

23. Signature John G. Schwenk, M.D.
Address 1337 S. Charles St. Date signed 9/4/48

Caseo

G66572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66572

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hosp. 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Cascio
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: m
5. Color or race: w
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years: 86 | Months | Days | If less than one day: hr. min.
9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Salvatore Cascio
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Cascio
15. Birthplace Italy

16 (a) Informant J. R. Alberto
(b) Address 1707 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7-1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Rd
18 (a) Funeral director Joseph Fanaco Inc
(b) Address 3 E Fremont Ave
19 [redacted] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1948 at 2:20 M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1948 to Sept. 4 1948, and that I last saw him alive on Sept. 4 1948.

Immediate cause of death: myocardial infarction — Duration

Due to: Hypertensive Arteriosclerotic Cardiovascular Disease

Due to: Coronary Sclerosis

Other Conditions: Mesenteric Thrombosis, possible.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel S. Silverstein
Address West Balto Gen Hosp Date signed 9/7/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 66657 3

CERTIFICATE OF DEATH

Registered No. 8 b 2 a

G66573

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard, Inter Sts
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Frederick
(c) City or town New Windsor (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ESTELLA DEVILBISS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife Maurice Devilbiss | 6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr) Mch 18 1901

8. AGE: Years 47 | Months unknown | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

PARENTS
12. Name Harry Lowman
13. Birthplace Md.

MOTHER
14. Maiden Name Pearl Haines
15. Birthplace Md.

16 (a) Informant Maurice Devilbiss
(b) Address New Windsor Pa.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-7-48 (month) (day) (year)
(c) Cemetery or crematory Lingamore
Location Unionville, Fred. Co. Md.

18 (a) Funeral director C. M. Watts
(b) Address Winfield Md.

SEP 5 - 1948 (Date rec'd by registrar) (b) Huntingtown Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1948 at 8-10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to Sept 4 1948 and that I last saw h alive on Sept 4 1948

Immediate cause of death	Duration
cardio-respiratory failure	
Due to Cerebro-vascular accident	
Due to Malignant hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature Jos Shea
Address Univ Hospital Date signed 9/5/48

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G66574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66574

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 W. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Jajeczynska (Yazvick)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Ukrainia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name —
13. Birthplace Ukrainia

MOTHER
14. Maiden Name —
15. Birthplace Ukrainia

16 (a) Informant Jennette Venavage
(b) Address 1523 Church St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7-48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. B. Tialkowski
Address 2007 Eastern Ave

19 (a) [illegible] (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1948 at 7:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5, 1948 to Sept 2 1948, and that I last saw him alive on Sept 2 1948.

	Duration
Immediate cause of death Respiratory failure - Pulmonary edema;	
Due to Hypostatic Pneumonia	1 wk.
Due to	
Other Conditions Hemiplegia, Rt side - cerebral accident. Arteriosclerosis	3 wks.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arvin Goldman M. D.
Address 706 [illegible] Date signed 9/4/48

VS 150

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G666575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G666575

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1608 Cherry St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1608 Cherry St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Irene Skrenchuk

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-5456

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Wasil Skrenchuk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Not known

8. AGE: Years About 52 | Months | Days | If less than one day hr. min.

9. Birthplace Russian (town, county, and state)

10. Usual Occupation Helper Hotel

11. Industry or business

FATHER 12. Name Mike ?

13. Birthplace Russian

MOTHER 14. Maiden Name not know

15. Birthplace Russian

16 (a) Informant Wasil Skrenchuk

(b) Address 1608 Cherry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 6-48 (month) (day) (year)

(c) Cemetery or crematory Holy Trinity Russian

Location Ebridge Md

18 (a) Funeral director John A Greblunchas

(b) Address 423 S. Paca St

19 (a) Sept 6 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1948 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Sept 3 1948.

That I last saw her alive on Sept 3 1948.

Immediate cause of death Carcinoma of the cervix with metastases — Duration 1½ years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Tilney R. Gehlert Jr M. D.

Address 4700 Pimlico Rd. Date signed Sept. 4 1948

G66576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66576

Registered No. 1224

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Kent
(c) City or town Rockhall Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Tessie Poole

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 9-27-1877

8. AGE: Years: 71 | Months: 11 | Days: 9 | If less than one day: hr min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Otha Fogwell
13. Birthplace: Md

MOTHER
14. Maiden Name: Amanda Schaffer
15. Birthplace: Md

16 (a) Informant: Hospital Records
(b) Address: — — — — — —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 8-48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balto. Md.

18 (a) Funeral director: Ellsworth Armacost
(b) Address: 3911 Liberty Heights Ave

19 (a) (Date rec'd by Registrar) (b) Registrar

SEP 8 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5/48 (Day) at 11:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29-48 to 9-5-48 and that I last saw her alive on 9-5-48

Immediate cause of death: Pulmonary Embolism.
Duration: 10 Min

Due to: Post-operative Phlebothrombosis.

Due to:

Other Conditions: Ventral hernia.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Carlton T. Hall M.D.
Address: St. Agnes Hosp. Date signed: 9/6/48

1002

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G66577 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution: Maryland Gen. Hosp.
(d) Length of stay in hospital or inst. (~~yrs., mos.~~ or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Bryonne Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Elizabeth Green

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	M

6 (b) Name of husband or wife Geo. W
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1869

8. AGE: Years	Months	Days	If less than one day
79	0	3	— hr. — min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name John Zapf
13. Birthplace Germany

MOTHER
14. Maiden Name Kathryn ?
15. Birthplace Germany

16 (a) Informant Geo. E. Green (son)
(b) Address Brookhaw - Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director C. Frank Bro
(b) Address 1300 Harford Rd

(Date rec'd by registrar) 9 Sep 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5-48 19 at 11 00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1948 to 9-5 1948 and that I last saw h[illegible] alive on 9-5 1948.

Immediate cause of death Cardio - Respiratory failure

Duration
—
—
—

Due to Generalized Carcinomatosis

Due to Carcinoma of ovaries

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 9-2-48

Major findings of operation: 9-2-48 Carcinomatosis, generalized

of autopsy Carcinomatosis generalized

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature C. K. Bandler M. D.
Address Md. Gen. Hosp. Date signed 9-5-48

VS 15)

G66578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

Registered No. G66578

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine C. Kernan (KERNAN)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	seperated

6 (b) Name of husband or wife Walter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 16 1900

8. AGE: Years	Months	Days	If less than one day hr.	min.
48	4	18		

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business

FATHER
12. Name Charles C. Schorer
13. Birthplace Balto Md

MOTHER
14. Maiden Name Annie E Bolst
15. Birthplace Balto Md.

16 (a) Informant Mrs. Carroll C. Gordon
(b) Address 5912 Audrey Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Lee
(b) Address 1301 Harford Rd

19 (a) 1948 (Date received by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1948, at 5 A.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to hcr death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to
Inhaling gas

Due to

Other Conditions Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/7/48 at about 5 00 P.M.
(b) Where did injury occur? 1217 N. Calvert St
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Gas inhalation from gas range in kitchen

23. Signature [illegible] Medical Examiner. M.D.
Date signed 9/8/48

VS 151

G66579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G66579

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: University Hospital

(c) Hospital or institution: Lombard & Green Sts

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days

(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. ~~1676 Oakley St~~ 1681 Cliftview Ave

(If inside city, give ward and section)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME MARGARET R PIPINO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Walter Pipino Jr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28 - 1921

8. AGE: Years 27 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name MILTON CANTWELL

13. Birthplace Md.

MOTHER 14. Maiden Name Dorothy Elizabeth Reid

15. Birthplace Md.

16 (a) Informant Walter Pipino Jr.

(b) Address ~~Unknown~~ Same

17 (a) Burial (b) Date thereof 9-8-48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director J Burke

(b) Address 3 East Maryland Ave

19 (a) (b)

(Date of registration) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1948 to Sept 4 1948, and that I last saw her alive on Sept 4 1948.

Immediate cause of death	Duration
Pulmonary Embolus	
Due to Cardiac failure	
Due to Rheumatic cardiac Vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: cardiac enlargement, mitral stenosis, pulmonary

of autopsy: embolus

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. S. Klein

Address Univ Hospital Date signed 9/9/48

Holland

G66580 CERTIFICATE CORRECTED 9-1-50

BALTIMORE CITY HEALTH DEPARTMENT

ES-119601

CERTIFICATE OF DEATH 130

(G66580)

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Balto. City Hospitals. 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo. 23 days

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. 9

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2527 Frances St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Sumner F. Bagwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col. (W)

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Kate

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 31, 1876

8. AGE: Years 71 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation Laborer - Coast Guard

11. Industry or business

FATHER

12. Name Isaac Bagwell

13. Birthplace ? Va

MOTHER

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant RECORDS - Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Sept. 7, 1948

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland

(b) Address 163 Dundalk Blvd.

19 (a) Rec'd by registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3 1948 at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1948 to 9-3- 1948

and that I last saw him alive on 9-3 1948

Immediate cause of death: For advanced pulmonary tuberculosis with cavitation — Duration: 10 mos.

Due to

Due to

Other Conditions Diabetes mellitus — Duration: 5 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Margaret A. Moran M. D.

Address Baltimore City Hospitals Date signed 9-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

G66581
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution:
Gmeral German Aged Peoples Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna L. Bockstie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1863

8. AGE: Years 85 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Franz H. Bockstie
13. Birthplace Germany

MOTHER
14. Maiden Name Anna M. Schuman
15. Birthplace Germany

16 (a) Informant Mr. J. George Walz,
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location

18 (a) Funeral director Harry A. Bockstie
(b) Address 4101 Edmondson Ave.

19 (a) 9/6/48 (Date rec'd by registrar) (b) Evelyn M. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5/48. 19 12-noon. at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1/48 19 to Sept 5/48. and that I last saw her alive on Sept. 1/48

Immediate cause of death	Duration
Broncho-Pneumonia	7 days
Due to	
Due to	
Unknown.	
Other Conditions Chronic Endocarditis.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Waldschmidt M.D.
Address 933 Hanover St. Date signed Sept. 5/48

VS 150

107

G66582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

G66582 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4710 Norwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4710 Norwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katharine Waldschmidt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Married

6 (b) Name of husband or wife Henry Waldschmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1889

8. AGE: Years	Months	Days	If less than one day
59	6	22	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Krausz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Schneider
15. Birthplace Balto. Md.

16 (a) Informant Dr. Henry Waldschmidt
(b) Address 4710 Norwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Luitze
(b) Address 4101 Edmondson Ave.

19 (a) 9/7/48 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3/48. 19 7/48 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1/48 to Sept. 3/48. and that I last saw her alive on Sept. 3/48.

Immediate cause of death	Duration
Gastro-Intestinal Adeno-Carcinoma.	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Waldschmidt M.D.
Address 933 Hanover St. Date signed Sept. 5/48.

VS 150

1202 St Paul

666583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

✓ Registered No. 666583

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave.
(c) Hospital or institution:
Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 E. 29th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline E. Swein Carrie E. Swein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Married

6 (b) Name of husband or wife Peter C. Swein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1877

8. AGE: Years	Months	Days	If less than one day
70	8	26	hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hartsel Center
13. Birthplace Ohio

MOTHER
14. Maiden Name Minnie ---------
15. Birthplace Ohio

16 (a) Informant Peter C. Swein
(b) Address 1924 E. 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7/48 (month) (day) (year)
(c) Cemetery or crematory Lorriana Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Weitzle.
(b) Address 4101 Edmondson Ave.

19 (a) 9/6/48 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4 1948 at 21 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1946 to 9/4 1948, and that I last saw him alive on 9/2 1948

Immediate cause of death Coronary occlusion. — Duration 1 hr.
Due to Arteriosclerosis. — 5 yrs.
Due to Hypertension — 5 yrs.
Other Conditions cerebral hemorrhage. — 2 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carl Tom M. D.
Address 1202 St Paul Date signed 9/7/48

VS 150

G66584

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66584
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 350 Herring Court
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 350 Herring Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HAZEL P. KENDRICK

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry J. Kendrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 30, 1892

8. AGE: Years: 56 | Months: 0 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Moyer, Penna. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Benjamin W. Williams
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Elizabeth Holland
15. Birthplace: Penna.

16 (a) Informant: Mr. G. S. Kendrick
(b) Address: 8501 Chestnut Oak Rd. Towson, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)
(c) Cemetery or crematory: Sylvan Heights
Location: Uniontown, Pa.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 5 1948 (Date rec'd by registrar) (b) [illegible] (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 5, 1948 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4 1948, to Sept 5 1948, and that I last saw h[illegible] alive on Sept 5 1948.

Immediate cause of death: Cerebral Hemorrage — Duration: 9/5/48
Due to: Chr. Myocarditis — 1947
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Paul Brame M. D.
Address 1663 W. North Ave Date signed 9/6/48

G8585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66585

Registered No. 84)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins and Catons Ave.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Frederick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A. Whiting

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Dr Lewis B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1912

8. AGE: Years 36 | Months 5 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David B. Ford
13. Birthplace Maryland

MOTHER
14. Maiden Name Pearl A. Ahern
15. Birthplace Maryland

16 (a) Informant Mrs. Ford
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Maryland

18 (a) Funeral director Wm. Cook, Funeral Mansion
(b) Address 1217 St. Paul Street

19 (a) SEP 7 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5 1948 at 8:30 PM

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Heart Failure

Due to Auricular Fibrillation

Other Conditions Neurogenic Shock Hysteria.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McClellan M.D.
Medical Examiner.
Date signed 9-6-48

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G666586

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1450 N. Carolina St.
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Carvel Road, Pasadena, Md. (If rural give location)
(e) Citizen of foreign country? No. Yes or (No)
If yes, name country

3 (a) FULL NAME Mrs. Catherine Petronella Ruby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Carl Ruby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-23-12

8. AGE: Years 36 | Months 0 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Hse wife

11. Industry or business

FATHER
12. Name Joseph Mitchell
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Dicased
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)
(c) Cemetery or crematory London Pk. Cem
Location Frederick Ave.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 SEP 7 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1948, at 5:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 1948 to 9-4 1948.
and that I last saw her alive on 9-4 1948

Immediate cause of death Pulmonary arrest-

Duration

Due to Tuberculosis (Pulmonary)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)
(Specify)
(e) Means of injury

23. Signature John Rabbage, M.D. M. D.
Address St. Joseph Hosp. Date signed 9-4-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666587

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins and Catonsville Ave
(c) Hospital or institution:
St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Baltimore~~
(c) City or town Catonsville (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Frederick Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Whiting II

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1930

8. AGE: Years 13 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lewis B Whiting
13. Birthplace Balto Co.

MOTHER
14. Maiden Name Catherine Ford
15. Birthplace md.

16 (a) Informant Dr Lewis B Whiting
(b) Address 319 Med Arts Bldg

17 (a) Burial (b) Date thereof 9/7/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Balto Co.

18 (a) Funeral director Wm Cook Inc.
(b) Address 217 St Paul st

19 (a) SEP 7 - 1948 (b) Baltimore Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5 1948, at 4:15 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia and Shock

Due to 2nd° and 3rd° Burns 90% body surface

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-4-48 at 2:15 P.M. Baltimore
(b) Where did injury occur? Near Catonsville ~~Baltimore~~ Co. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? On Farm While at work? No
(d) Means of injury Burns from Gasoline explosion.

23. Signature John B. McGuiden M.D.
Medical Examiner
Date signed 9-5-48

VS 191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

✓ 666588 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4410 Roland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4410 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

14

3 (a) FULL NAME Harry L. Bennett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Emily Stark Bennett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 17th 1876

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71	10	18		

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Real Estate

FATHER
12. Name Lewis N. Bennett
13. Birthplace Md.

MOTHER
14. Maiden Name Harriett Royston
15 Birthplace Md.

16 (a) Informant Miss Emily Bennett
(b) Address 4410 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)
(c) Cemetery ~~crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 SEP 7 - 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 - 1948, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Sept 1948, and that I last saw him alive on Sept 1948.

Immediate cause of death	Duration
Coronary Occlusion	
Due to	
Due to	
Other Conditions Duodenal Ulcer	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury William J. Bennett

23. Signature
Address 5216 Roland Ave Date signed Sept 8th 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

94a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

✓ 666589 Registered No.

666589

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Filbert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Polyanskie (Annie Polunsky)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Stanley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Lith. (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith.

MOTHER
14. Maiden Name ?
15. Birthplace Lith.

16 (a) Informant Stanley Polunsky
(b) Address 1317 Filbert St

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Sept 7-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Anundel County

18 (a) Funeral director Joseph Kasmakas Inc
(b) Address 602 Washington Blvd

19 SEP 7 - 1948 (Date rec'd by Registrar) **(b)** [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1948, at 6 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 8/6 1948 to 9/4 1948 and that I last saw her alive on 9/3 1948.

Immediate cause of death Cerebral embolism.

Due to

Due to

Other Conditions Cirrhosis. Malignancy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Carcinoma of pancreas

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Maryland Ave Date signed 9/4/48

VS 150

G66590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G66590

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4017 Belle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah L. Ginsberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	wh	Married

6 (b) Name of husband or wife Samuel L
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-7-1877

8. AGE: Years	Months	Days	If less than one day
70 71	9	29	hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Goldberg
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Samuel L Ginsberg
(b) Address 4017 Belle Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-48 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Windsor Mill Road
18 (a) Funeral director Jack Lewis Inc
(b) Address 2466 Eutaw Place
19 Date received by local registrar (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1948, at 5:00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/1 1948, to 9/6 1948, and that I last saw her alive on 9/6 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Diabetes Mellitus Old Cerebrovascular accident	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marjorie Oxman, M. D.
M. D.
Address Sinai Hosp. Baltimore Date signed 9/6/48

VS 150

107

66591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 66591

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 27c
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4825 Palmer Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Lerner (LERNER)

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Ethel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

MOTHER / FATHER
12. Name Meyer
13. Birthplace Russia
14. Maiden Name Tobye
15. Birthplace Russia

16 (a) Informant Harry Lerner
(b) Address 4825 Palmer ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 2166 Eutaw Place

SEP 7 - 1948 (b) (Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1948, at 11:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/a /48 to 9/6/48, and that I last saw him alive on 9/6 1948.

Immediate cause of death	Coronary Thrombosis	
Due to	Arteriosclerotic cardio-vascular disease	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Juanita B. Landau M. D.
Address Sinai Hospital Date signed 9/6/48

X

666592

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 183

Registered No. 666592

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pond—1100 Blk. Frankfirst Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 638 Smithson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lester Chisley

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1934

8. AGE: Years 13 | Months 11 | Days 24 | If less than one day hr. 1 min.

9. Birthplace md
(Town, county, and state)

10. Usual Occupation School
11. Industry or business

FATHER
12. Name James Chisley
13. Birthplace md

MOTHER
14. Maiden Name Marie Carroll
15. Birthplace md

16 (a) Informant Maria Wilson
(b) Address 638 Smithson St

17 (a) Burial (b) Date thereof 9-7-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George G. Kelson
(b) Address 1405 Pennsylvania Ave

19 (a) SEP 7 - 1948 (b) Washington Funeral Home
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3, 1948, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ probably, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found: 9-3-48 at 1:45 P M
(b) Where did injury occur? Found: Arundel Sand & Gravel Co 1100 Blk. Frankfirst Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work?
(d) Means of injury Found drowned

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/3/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104a

G66593
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1207 Whatcoat Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Whatcoat Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: MINNIE HENRY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Leroy Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) month a 1899

8. AGE: Years 49 | Months | Days - | If less than one day: hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name John Hackett

FATHER 13. Birthplace md

MOTHER 14. Maiden Name —

MOTHER 15. Birthplace —

16 (a) Informant Georgeanna Johnson

(b) Address 1153 N. mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-48 (month) (day) (year)

(c) Cemetery or crematory not Calvary

Location md

18 (a) Funeral director George B. Nelson

(b) Address 1303 Pennsylvania Ave

SEP 7 - 1948 (Date rec'd by registrar)

(b) Funeral Director, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1948, at 10:15 M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uterus Perforating Infection

Due to

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner

Date signed Sept 7 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66594

ES-113829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66594

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mo. 26 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 China St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Boyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Feb. 3. 1927

8. AGE: Years	Months	Days	If less than one day
21	7	1	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Willis Boyer
13. Birthplace Md.

MOTHER
14. Maiden Name Maggie Johnson
15. Birthplace Md.

16 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James Astarjes
(b) Address 1142 W Fredk St

19 SEP 7 1948 (Date rec'd by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4-48 19 48 at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 19 47 to 9-4 19 48, and that I last saw her alive on 9-4 19 48.

Immediate cause of death Bilateral far advanced pulmonary Tuberculosis with Cavitation — Duration 14 months

Due to

Due to

Other Conditions Tuberculosis spleen, pleura larynx & pericardium
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ag. Bronx & Cardiac enlargement

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M. D.
Address Baltimore City Hosp. Date signed 9-5-48.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 10a

Registered No. G66595

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 E. Clement st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 E. Clement st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John G. Steencken

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-09-2447

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hermine Steencken
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) May 9-1876

8. AGE: Years	Months	Days	If less than one day
72	3	27	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Tool Fitter
11. Industry or business Shipping Co.

FATHER
12. Name Frederick Steencken
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Lankenau
15. Birthplace Germany

16 (a) Informant Hermine Steencken
(b) Address 1602 E. Clement st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 8-1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Mr & Mrs. John W. Cuter Son
(b) Address 531 Edmondson Ave

19 SEP 7 1948 (Date rec'd by local registrar) (b)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1948, at 12 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1948 to Sept 5 1948, and that I last saw h alive on Sept 4 1948.

Immediate cause of death	Duration
Terminal Coma	32
Bronchial Pneumonia	3d
Due to Mitral Regurgitation	1yr
Arterio Sclerosis Hypertension	14yr
Due to Chronic Interstitial Nephritis	14yr

INTERSTITIAL

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. F. A. Stevens M. D.
Address 3818 Harford Av Date signed 9-6-48

666596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 666596

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 27
(d) Length of stay in hospital or inst. (~~yrs.~~ ~~mos.~~ ~~da~~ days) 2
(e) Length of stay in Baltimore (yrs., ~~mos.~~ ~~days~~) 91

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 Eastern Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W. Jamart (Jamart)

3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
M	W	Married

6 (b) Name of husband or wife Louise
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept 3 1857

8. AGE:

Years	Months	Days	If less than one day
91	0	3	— hr. — min.

9. Birthplace Baltimore Maryland (Town, county and state)
10. Usual Occupation none Retired
11. Industry or business

FATHER
12. Name Louis Jamart
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name CATHERINE SEAGER
15. Birthplace Md

16 (a) Informant Mrs. Charles Scherer
(b) Address ? Baltimore 5004 Walker Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location

18 (a) Funeral director J. Bryk
(b) Address 501 Hartford Rd

19 SEP 7 - 1948 (Date rec'd by registrar) Huntington for Baltimore Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1948, at 8:31 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4 1948 to 9-6 1948.
and that I last saw him alive on 9-5 1948.

Immediate cause of death	Duration
Respiratory failure	1 day
Due to Terminal bronchopneumonia	2 days
Due to Fracture, hip, rt.	2 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9-4-48 at ? M
(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Elizabeth Nursing While at work? No (Specify type of place) Home
(e) Means of injury Fall - slipped on ball to floor

23. Signature W. Samuel A. Harris M.D.
Address Md. Gen. Hosp. Date signed 9/6/48

VS 150 to be reported Med. Ex. For B.C. J. Subinski, by X Horace J. Maddox, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

562

Registered No. G66597

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1st & Division St.
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name of town)
(d) Street No. 726 Bradley St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Magnolia B. Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fe

5. Color or race Negro

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Harry Matthews

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-29-1900

8. AGE: Years 48 Months 8 Days 5½ If less than one day hr. min.

9. Birthplace Cadiz, Va (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

MOTHER / FATHER

12. Name unknown

13. Birthplace Va

14. Maiden Name unknown

15. Birthplace Va

16 (a) Informant Harry Matthews

(b) Address 726 Bradley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Bala City

18 (a) Funeral director Wm A Jackson

(b) Address 916 Penna Ave

19 (a) Received by registrar SEP 7 1948 (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4/48 at 5:30 A M

21. I certify that death occurred on the date above stated, and I attended deceased from 9/1/48 to 9/4/48.
and that I last saw her alive on 9/4/48.

Immediate cause of death Acute Myocardial Failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/3/48

Major findings of operation: Fibromyomata uteri; Umbilical Hernia

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature

Address Provident Hosp Date signed 9/4/48

Please print plainly in ink. Be sure that the information given is correct. Be careful to see that age is correctly stated. Physicians: please write the cause of death clearly and legibly.

VS 15

666598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

666598 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 E. Biddle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 E. Biddle Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas Schluttanhafer

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Hannah Himmelheber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7, 1880

8. AGE: Years 68 | Months - | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired- Bethelehem Steel Co
11. Industry or business

FATHER
12. Name Henry C. Schluttanhafer
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary Birmingham
15. Birthplace Baltimore, Md.

16 (a) Informant Ruth Otradevec
(b) Address 717 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Schimunek Funeral Home Inc.
(b) Address 2601-05-05 E. Madison Street

19 (a) SEP 7 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4, 1948 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29th 1948 to Sept 4th 1948
and that I last saw h alive on Sept 4th 1948.

Immediate cause of death Heart Failure — Duration 24hrs
Due to Myocarditis — 1 year
Due to Arteriosclerosis — 2 years
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)
(e) Means of injury
23. Signature L E Poulton
Address 1512 Eastern Ave Date signed 9/7/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 199

6599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 666599

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 N. Montford Ave #13 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William Jung
3 (b) If veteran, name war | 3 (c) Social Security Account No.
4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife Lillian M. Keller
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 3, 1884
8. AGE: Years 64 | Months 3 | Days 2 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business A. S. Abell Co.

FATHER
12. Name John W. Jung
13. Birthplace Holland

MOTHER
14. Maiden Name Christina Wickman
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lillian J. Batzer
(b) Address 216 Murdock Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)
(c) Cemetery or Baltimore
Location North Ave. & Rose St. Balto. Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 SEP 7 - 1948 (Date rec'd by Registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1948, at 5:50 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/3 1948 to 9/5 1948, and that I last saw him alive on 9/5 1948

	Duration
Immediate cause of death: Cardio-respiratory failure	12 hours
Due to Cerebral hemorrhage	4 days
Due to Hypertensive C-V Disease	? years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred H. Dann
Address Maryland General Hosp. Date signed 9/5/48 (M. D.)

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G66600

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdale Road
(c) Hospital or institution: Anderson Convalescent Rest Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4506 Carlesen Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Samuel Ender

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Edmund A. Ender

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1862

8. AGE: Years	Months	Days	If less than one day
86	2	9	hr. min.

9. Birthplace Burlington, Conn.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unk Samuel
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Edmund S. Ender
(b) Address 4506 Carlesen Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9 1948 (month) (day) (year)
(c) Cemetery or crematory Evergreen Cemetery
Location New Haven, Conn.

18 (a) Funeral director E. Willis Simonds
(b) Address 4510 Liberty Heights Ave.

19 Sept 7 - 1948 Huntington Maryland
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6" 1948 at 5:55 M

21. I certify that death occurred on the date above stated, that I attended deceased from June 12 1947 to Sept 6 1948 and that I last saw he alive on Sept 3 1948.

Immediate cause of death	Duration
1) Primary Carcinoma of Colon	1 yr.
Due to	
Due to	
Other Conditions Cirrhosis - Selerotic Heart Disease	- 5 yrs.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl F. Chambers M. D.
Address 4108 Liberty Hts Date signed 9/7/48

VS 150

G66601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66601 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Baltimore
(c) City or town Monkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emory Nicholas Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No. NONE

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11/8/72
8. AGE: Years 75 | Months 10 | Days 28 | If less than one day hr. min.
9. Birthplace (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name JAMES JOHNSON
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name ANNIE WILLIAMS
15. Birthplace UNKNOWN

16 (a) Informant Patient
(b) Address MONKTON MD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Sept 9-48 (month) (day) (year)
(c) Cemetery or crematory UNION CHAPEL
Location MONKTON, MD

18 (a) Funeral director Howard S Hopkins
(b) Address Lutherville Md

19 SEP 7 - 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1948 at 5.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1948 to 9/6 1948, and that I last saw him alive on 9/6 1948.

Immediate cause of death: Hypostatic pneumonia — Duration 2 days
Due to Right sided hemiplegia
Due to Hypertensive arterio sclerotic cardiovascular disease
Other Conditions Gangrene of rt. foot.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Hyde M.D.
Address Provident Hosp Date signed 9/6/48

VS 150

666602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 666602

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 Ridgehill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY C. INEMER, Sr.

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Anna M. Inemer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): May 3, 1883

8. AGE: Years: 65 | Months: 4 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Chief Clerk
11. Industry or business: Balto. Police Dept.

FATHER
12. Name: Harry C. Inemer
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Suzanna Brown
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Anna M. Inemer
(b) Address: 2120 Ridgehill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 SEP 7 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 6 1948, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 - 30 1948. to 9 - 6 1948. and that I last saw h[illegible] alive on 9 - 6 1948.

Immediate cause of death: Respiratory failure — Duration:
Due to: Bilateral Pneumonia
Due to:
Other Conditions: Cerebral Arterio-Sclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Frederick A. Erichs Jr. M. D.
Address Bon Secours Hosp. Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Avs 150

166603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 166603

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1340 Presstman (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Culley

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female
5. Color or race: colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 | 24 | 1897

8. AGE: Years 50 | Months 9 | Days 11 | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation domestic
11. Industry or business

FATHER
12. Name Joe Henderson
13. Birthplace Va

MOTHER
14. Maiden Name ?
15. Birthplace Va

16 (a) Informant Daisy Stepter
(b) Address 1340 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 | 9 | 48 (month) (day) (year)
(c) Cemetery or crematory Northumberland Co.
Location Northumberland Co. Va

18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Presstman St

19 (a) [illegible] (b) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1948 at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21-48 19 to 9-4-48 19 and that I last saw h[illegible] alive on 9-4-48.

Immediate cause of death Resp. failure — Duration

Due to Brain abscess

Due to septicemia

Other Conditions pernicious anemia, cholecystitis, diabetes mellitus, blind

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] White
Address [illegible] Hosp. Date signed M D 9-4-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

8aa

G66604 GM. 122363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G66604 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9 Dys
(e) Length of stay in Baltimore (yrs., mos., or days) 61 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1329 S. Clinton St. / Z 24
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Gaphardt

3 (b) If veteran, name war none.

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Harvey Gaphardt.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27-1870

8. AGE: Years	Months	Days	If less than one day
78	6	6	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Horse Wife
11. Industry or business

FATHER
12. Name Christopher Moll (D)
13. Birthplace Germany

MOTHER
14. Maiden Name Madeline ? (D)
15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 7 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Edmondson Ave & Rendall St.

18 (a) Funeral director Rendall Chapel
(b) Address 1900 W. Baltimore St.

19 SEP 7 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 3- 1948, at 9.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8- 24- 1948 to 9- 3- 1948, and that I last saw her alive on 9- 3- 1948.

Immediate cause of death Bronchopneumonia — Duration days

Due to

Due to 17 yrs

Other Conditions Arteriosclerosis, HCVD + yrs
ECPC following, diab. mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: ✓

of autopsy Arteriosclerosis, HCVD ECPC

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Balto City Hosps Date signed 9/5/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

G66605 BC-48-19478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G66605

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Mercy Hosp. 3-R
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Thames St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Girl Sadler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-1-48

8. AGE: Years — | Months — | Days 4 | If less than one day hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Clifford Sadler
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Helen Schmidt
15. Birthplace Baltimore Md

16 (a) Informant Odell Sadler
(b) Address 1514 Thames St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-48 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore

18 (a) Funeral director George P. Radcliffe
(b) Address Fulton Ave & Fayette St.

19 9-7-48 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1948 at 1 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1948 to 9/5 1948 and that I last saw her alive on 9/5 1948

Immediate cause of death Resp. Failure — Duration 1 hr

Due to Pneumonia

Due to Atelectasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature V. A. Bitzpatrick

Address Mercy Hosp Date signed 9/8/48

VS 150

Correct age is extremely important. Physician: please write the cause of death clearly and legibly.

G66606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G66606

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4220 Belmar Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4220 Belmar Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. McKewen

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Margaret C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1861

8. AGE: Years 87 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Henry McKewen
13. Birthplace Ireland

MOTHER
14. Maiden Name Agnes Byrne
15. Birthplace Scotland

16 (a) Informant Margaret C. Brackon
(b) Address 4220 Belmar Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8 48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Dippel Bros.
(b) Address 7110 Belair Rd.

19 (a) SEP 7 - 1948 (Date rec'd by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1948 at 2:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1946 to Sept. 5 1948 and that I last saw him alive on Aug. 28 1948.

Immediate cause of death	Duration
CEREBRAL THROMBOSIS	10 days
Due to CEREBRAL ARTERIO-SCLEROSIS	5 years.
Due to	
Other Conditions MYOCARDIAL DEGENERATION SENILITY	3 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Macken M.D.
Address 630 Belair Rd (6) Date signed 9/6/48

83B

Vs 150

G66607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927 ✓

Registered No. G66607

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2526 Barclay Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2526 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MAY M. WHITTLE

3 (b) If veteran, name war ##
3 (c) Social Security Account No. ---

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1870

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Athome

11. Industry or business

FATHER 12. Name T. Stockton Whittle
13. Birthplace Westminister, Md.

MOTHER 14. Maiden Name Berdelia O'Brian
15. Birthplace Ireland

16 (a) Informant Miss Francis Whittle
(b) Address 2526 Barclay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) SEP 7 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2nd 1948, at 11P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1948 to Sept 2 1948, and that I last saw h alive on Sept 2 1948.

Immediate cause of death: Chronic Endocarditis — Duration: 3 months
Due to: Arterio Sclerosis — 1 year
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [illegible]
Address 1279 William St. Date signed 9/3/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66608

WENZEL

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66608 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hundred Block W. 37th St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 W. 37th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSHUA H. WENZEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Nellie Wenzel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 31, 1871

8. AGE: Years 76 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Mail Clerk

11. Industry or business

FATHER
12. Name George Wenzel
13. Birthplace Baltimore

MOTHER
14. Maiden Name Katherine Kibler
15. Birthplace Germany

16 (a) Informant Nellie W. Wenzel
(b) Address 822 W. 37th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8, 1948 (month) (day) (year)
(c) Cemetery or crematory London Park
Location

18 (a) Funeral director Paul E. Chenoweth Sr.
(b) Address 7615-17 Liberty Road

19 (a) [illegible] 17 - 1948 (Signature of registrar) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1948 at 3 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Sept 5 1948, and that I last saw him alive on Sept 5 1948.

Immediate cause of death: Cardio-respiratory failure — Duration

Due to: Cerebro-vascular accident

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Univ. Hospital Date signed 9/5/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 666609

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3433 Frederick Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3433 Frederick ave. (If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME George F. Rauch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Annie E.

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1877

8. AGE: Years	Months	Days	If less than one day
70	10	16	4 hr. — min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Yeoman

11. Industry or business

FATHER 12. Name Charles F. Rauch

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Louise Kahn

MOTHER 15 Birthplace Germany

16 (a) Informant Mrs. George F. Rauch

(b) Address 3433 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-48 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore

18 (a) Funeral director George A. Farley

(b) Address Fulton Ave & Fayette St.

19 (a) SEP 7 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1948 to Sept 5 1948.

and that I last saw him alive on Sept 5 1948

Immediate cause of death	Cardiac Failure	Duration
Due to	Cardio Vascular Disease	
Due to		
Other Conditions	Bronchiectasis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify)

(e) Means of injury

23. Signature Albert Scarpati M. D.

Address 1724 W. Lombard Date signed Sept 17 '48

466610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 466610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2857 W LAFAYETTE AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2857 W LAFAYETTE AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN H CROSS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife JULIA CROSS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) APRIL-10-1868

8. AGE: Years 80 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation RETIRED CARPENTER

11. Industry or business —

FATHER
12. Name JAMES CROSS
13. Birthplace MARYLAND

MOTHER
14. Maiden Name NOT KNOWN.
15. Birthplace NOT KNOWN

16 (a) Informant JAMES CROSS
(b) Address 2857 W LAFAYETTE AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-9-48 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Bernard C Hunter
(b) SEPT - 1948 E Worthington Williamsport

19 (a) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 6 1948, at 3:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1948, to Sept 6 1948, and that I last saw h[illegible] alive on Sept 3 1948.

Immediate cause of death Myocardial Insufficiency — Duration several years

Due to Arterio sclerotic cardiovascular disease with hypertension

Due to congestive failure

Other Conditions Bronchitis (chronic)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Wm Michael

Address 2901 Edmondson Ave Date signed Sept 7 1948

VS 199

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66611

ES- 122722

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47c

Registered No. G66611

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 E. 21st. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Akers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of husband or wife ? ~~Maria Akers (D)~~ MARIE AKERS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1894

8. AGE: Years	Months	Days	If less than one day
54	6	17	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ~~Maria Akers (D)~~ ?
15. Birthplace ?

16 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial-
(Burial, cremation, or removal)
(b) Date thereof 9-8-48
(month) (day) (year)
(c) Cemetery or crematory WOODLAWN.
Location MD

18 (a) Funeral director Bernard C. Harlow
(b) Address 121 E. West St.

19 (a) SEP 7 - 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5- 1948 at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5- 1948 to 9-5-48 1948
and that I last saw him alive on 9-5- 1948

Immediate cause of death
Lobar pneumonia
? ~~carcinoma~~ ? tbc.
Duration 5 dys.

Due to Bronchogenic carcinoma c metastases to mediastinal nodes

Other Conditions Old coronary infarct. old tbc. Rt. hemiplegia old.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:
CONSOLIDATION
of autopsy: Consolidation RLL

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David H. Marcus M. D.
Address Balto City Hosp. Date signed 9-6-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97

Registered No. 666612

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) ~~Hospital or~~ institution: Home for the Aged Women
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Melia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife Minnie Goodwich
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. March 21, 1867

8. AGE: Years	Months	Days	If less than one day
81	5	15	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Richard Melia
13. Birthplace

MOTHER 14. Maiden Name Rose Dugan
15. Birthplace

16 (a) Informant ~~Sister~~ Sister-in-law
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wunderlich
(b) Address 900 East Fayette St

19 (a) SEP 7 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1948, at 11; P.M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 19[illegible], to [illegible] 2 1948.
and that I last saw him alive on Sept 4 1948.

Immediate cause of death	Duration
Edema Lungs	[illegible]
Due to [illegible]	[illegible]
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(e) Means of injury

23. Signature M. D.
Address Date signed

VS 150

G66613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G66613

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1537 Abbottson Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 Abbottson Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel T. Taylor

3 (b) If veteran, name war: None

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose J. McCullough

6 (c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Oct. 27th., 1887

8. AGE: Years: 60 | Months: 10 | Days: 8 | If less than one day: ########## min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Elevator Operator

11. Industry or business: Office Building

FATHER
12. Name: Charles Nicholas Taylor
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Laura Miles
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Rose J. Taylor--- Wife
(b) Address: 1537 Abbottson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Taylor Avenue, Balto: Co. Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) Signed by [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5th., 1948, at 5/38 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1948. to 9/5 1948.
and that I last saw him alive on 9/4 1948.

Immediate cause of death: Carcinoma of the Lung — Duration: 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence. at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Jos. S. Stein M.D.
Address: 111 W. Lafayette St. Date signed 9/7/48

V S 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66614 CERTIFICATE CORRECTED

HEALTH DEPARTMENT—CITY OF BALTIMORE G66614

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Northway Apts- 3700 N Charles ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isabel Pinkney (Mrs.) Bispham

(a) RESIDENCE NO. Northway Apts - 3700 N. Charles ST., 12-1 WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: William Newbold Bispham 1874

6 DATE OF BIRTH (month, day, and year): July 17 (1874)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74 (83)	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Andrew Caldwell Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Chestertown Maryland

12 MAIDEN NAME OF MOTHER: Sophia Pinkney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Miss Ethel R. Gray (sister)
(Address): Northway Apts. - City

15 Filed SEP 7 - 1948 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 5, 1948

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1948 to Sept. 5, 1948; that I last saw h[illegible] alive on Sept 5, 1948 and that death occurred, on the date stated above, at 10 45 p m.

The CAUSE OF DEATH was as follows:

Cerebral Thrombosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H. Truscheir M. D.

. 19 (Address) 1035 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Burial-Arlington National Cemetery — DATE OF BURIAL: Sept. 8-1948

20 UNDERTAKER: Stewart + Mowen Company — ADDRESS: 108 W. North. City

66615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 M

Registered No. 66615

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 Eastern ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Corolyn M. Zaworske

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 19 - 1946

8. AGE: Years	Months	Days	If less than one day hr.	min.
1	10	16		

9. Birthplace Balto. - Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Theodore F. Zaworski
13. Birthplace Balto. - Md.

MOTHER
14. Maiden Name Marie J. ~~Doctrat~~ Dietrich
15. Birthplace Balto. - Md.

16 (a) Informant Mario J. ~~Dietrich~~ Zaworski
(b) Address 2710 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 8-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) Filed ~~rec'd~~ by Registrar (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1948, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1948 to 9/5 1948, and that I last saw h~~e~~r alive on 9/5 1948.

Immediate cause of death	Duration
Heart failure	
Due to Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9/1/48

Major findings of operation: Cong. dislocation hip

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)
(e) Means of injury

23. Signature D. Schuehler M.D.
Address Bon Secours Hosp. Date signed 9/5/48

VS 150

G66616
B-96267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

G66616
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs. 11 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Wilmer Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 19, 1888

8. AGE: Years	Months	Days	If less than one day
59	11		hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER
12. Name John Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Maria Brodley
15. Birthplace Md.

16 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 7, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) SEP 7 1948 (Date rec'd by registrar) (b) Washington Witherspoon (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1 19 48 at 5:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 19 45 to 9-1 19 48
and that I last saw him alive on 9-1 19 48

Immediate cause of death	Duration
Cerebral Vascular Accident	2 hrs
Due to Hypertensive Cardiovascular Disease	5 yrs
Due to	
Other Conditions Bronchopneumonia. Lobar.	3 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Nielsen Jr. M.D.
Address Balto City Hosp Date signed 7 Sept 48

G66617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G66617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 252 N. Arlington Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: EARL E. DAVIS

3 (b) If veteran, name war

3 (c) Social Security Account No. 228-16-7074

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife Daisy Davis

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1915

8. AGE: Years	Months	Days	If less than one day
33	7	0	hr. min.

9. Birthplace Halifax Co., Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business United American Metal Corp.

FATHER
12. Name Clem Davis
13. Birthplace Va.

MOTHER
14. Maiden Name Catherine Barksdale
15. Birthplace Va

16 (a) Informant Daisy Davis
(b) Address 916-5th St. Lynchburg, Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-48 (month) (day) (year)

(c) Cemetery or crematory Halifax
Location Halifax Co., Va

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave

19 (a) SEP 7 - [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 9:55 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute pulmonary edema
Acute congestive cardiac failure
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 8-31-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66618

ES- 121119

108

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Balto. City Hospitals. 3-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 28 days.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 233 Albermarle St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Virginia Locke (Miss. Virginia Hill.)

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-26-6468

4. Sex F.

5. Color or race W

6 (a) Single, married, widowed, divorced. Sep.

6 (b) Name of husband or wife Albert Locke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1930?

8. AGE: Years 18 Months 11 Days If less than one day hr. min.

9. Birthplace Chattanooga Tenn. (Town, county, and state)

10. Usual occupation Telephone Operator

11. Kind of business/industry Telephone

12. [illegible] Hill

13. [illegible] Tenn.

14. Maiden Name [illegible] H. Mahan

15. Birthplace Pittsburgh Georgia.

16 (a) Informant Clyde F. Hill

(b) Address 233 S. Albemarle St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)

(c) Cemetery or crematory Suite. Cemetery.

Location North. & Milton.

18 (a) Funeral director Frank Delly Noce

(b) Address 322 S. High St.

19 (a) Date received (Registrar) SEP 7 1948 (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6 1948 at 11:25 A M

I certify that death occurred on the date above stated; that I attended deceased from 7-9- 1943 to 9-6- 1948, and that I last saw her alive on 9-6- 1948.

Immediate cause of death: Lobar pneumonia, rt lower lobe — Duration: 3 days.

Due to

Due to

Other Conditions Probable Hodgkins Disease — 1 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William A. Vinkins

Address Balto City Hosp Date signed 6 Sept 48 M D

NOTES

VS 150

X

BC-KP-18204

666619

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. 666619

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 West Hamburg Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy James (462395)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	black	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
0	0	0	4 hr. 35 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Leroy James
13. Birthplace Georgia

MOTHER
14. Maiden Name Alline Robinson
15. Birthplace North Carolina

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) SEP 7 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1948, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 22 1948, to August 23 1948, and that I last saw him alive on August 23, 1948.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul O'Brien M. D.
Address The Johns Hopkins Hospital Date signed 8-26-48

VS 150

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

G66620

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Middle River
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Navigator Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alvin Loudenmilch

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION 10 A

20. DATE OF DEATH Sept 7 1948, at 9 M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Sep.

6 (b) Name of husband or wife

6 (c) If [illegible], give age years

7. Birth date of deceased (mo., day, yr.) 10-13-1897

8. AGE: Years	Months	Days	If less than one day
50	10	25	hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER 12. Name John Loudenmilch
13. Birthplace

MOTHER 14. Maiden Name Edna Reynolds
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)
(c) Cemetery or crematory Harrisburg Pa.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19. SEP 8 - 1948 (Date rec'd by Registrar)

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6- 1948 to 9-7- 1948 and that I last saw h alive on 9-7- 1948

Immediate cause of death: Acute anterior myocardial infarction — Duration: 5 days

Due to Coronary Thrombosis

Due to Coronary arteriosclerosis

Other Conditions Duodenal diverticulum

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertram E. Sprague

Address JOHNS HOPKINS HOSPITAL Date signed 9/7/48

VS 150

66621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 66621

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 Aisquith St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: RAYMOND S. ADDISON

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-2390

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28th 1894

8. AGE: Years: about 54 | Months: 10 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Housemaid

11. Industry or business: Belvedere Hotel

FATHER 12. Name: Frank D. Addison

13. Birthplace: Balto Md

MOTHER 14. Maiden Name: Isabella C. Cunningham

15. Birthplace: Balto. Md.

16 (a) Informant: T. S. Addison

(b) Address: 5515 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)

(c) Cemetery or crematory Balto " Md.

Location

18 (a) Funeral director: William Cook Inc.

(b) Address: 1217 St. Paul St.

SEP 8 - 1948 (Date rec'd by Registrar)

(b) [illegible]

VS 151

No.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1948, at 6:35 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Frank Royston M.D.
Medical Examiner

Date signed 9-6-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66622

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2647 Aisquith St
(c) Hospital or institution: 9-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2647 N. Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry A. Schuldt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
Male	White	Widowed

6 (b) Name of ~~husband~~ or wife Sophia Schuldt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 12th 1877

8. AGE: Years	Months	Days	If less than one day
70	9	25	hr. min.

9. Birthplace Denmark (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Schuldt
13. Birthplace Denmark

MOTHER
14. Maiden Name Anna Fondoren
15. Birthplace Denmark

16 (a) Informant Henry Schuldt
(b) Address 2647 Aisquith St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 8 - 1948 (Date rec'd by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7th 1948, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1948, to Sept 7 1948, and that I last saw h~~im~~ alive on Sept 7 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 days.
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Kent Fisher M. D.
Address 1623 N Mad. St Date signed 9/7/48

666623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

666623
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 E. 21st St.
(c) Hospital or institution:
12 + 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 E. 21st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada Bowers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband William Bowers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 1st 1869

8. AGE: Years	Months	Days	If less than one day
79	8	6	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Noah Lankford
13. Birthplace Md.

MOTHER
14. Maiden Name Anna B. Atmah
15. Birthplace Va.

16 (a) Informant Willie M. Rich
(b) Address 417 E. 21st St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St.

19 SEP 8 - 1948 (Date rec'd by Registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7th 1948, at 11 35 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1937 to Sept 7 1948 and that I last saw h[illegible] alive on Sept 7 1948.

Immediate cause of death	Duration
Cardiovascular renal disease	
Due to	
Due to	
Other Conditions Carcinoma of rt breast	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack J Singer
Address 504 E Northern Date signed 9-7-48 M. D.

VS 159

131a

G66624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G66624

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2407 Reisterstown Rd.
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 Reisterstown Road. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ISRAEL E. SNEIDER.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-4359

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband or wife~~ Sedonia Sneider. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1887.

8. AGE: Years	Months	Days	If less than one day
61	6	18	hr. min.

9. Birthplace Lithuania. (Town, county, and state)
10. Usual Occupation Merchant.
11. Industry or business

FATHER
12. Name David W. Sneider,
13. Birthplace Lithuania.

MOTHER
14. Maiden Name Bluma Silverman,
15. Birthplace Lithuania.

16 (a) Informant Mrs. Sedonia Sneider,
(b) Address 2407 Reisterstown Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/48. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director [illegible]
(b) Address 1902 Eutaw Place.

19 SEP 8 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7th. 1948, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from about 1941. Sept 7 1948 and that I last saw him alive on Sept 4 1948.

Immediate cause of death: Pulmonary Edema — Duration 1 day

Due to Carcinoma of Intestine (about 1 yr)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1947

Major findings of operation: Carcinoma of Intestine

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury GUSTAV HIGH STEIN

23. Signature [illegible] M. D.
Address 3503 Garrison Blvd. Date signed

VS 150

666625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 666625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4606 York Rd
(c) Hospital or institution: 27

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4606 York Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Olivia Mary Mattea

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John R. Mattea
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1888

8. AGE: Years	Months	Days	If less than one day
59	11	5 25	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Silas B. Wells
13. Birthplace Virginia

MOTHER
14. Maiden Name Lula R. Bader
15. Birthplace Virginia

16 (a) Informant John R. Mattea
(b) Address 4606 York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belgadi Rd

18 (a) Funeral director John A. Moran
(b) Address 3050 E. Balt. St.

1948 SEP 8 1948 (Date rec'd by Registrar) (By) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1948 at 9.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to Sept 1948, and that I last saw her alive on Sept 1-1948.

Immediate cause of death Lymphosarcoma - Blastomata (Carcinoma of the lymph-glands)

Duration 4 months

Due to

Due to

Other Conditions ① Severe anemia ② Loss of weight

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Manuel Kodaro M. D.
Address 4624 York Road Date signed Sept 7 1948

VS 130

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 937

Registered No. 666626

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 E Chase St
(c) Hospital or institution:
St Frances Convent
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Agnes Diamond O.S.P.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26, 1890

8. AGE: Years	Months	Days	If less than one day
57	10	11	hr. min.

9. Birthplace Richmond Va (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mother M. Teresa O.S.P.
(b) Address 501 E Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location

18 (a) Funeral director McDuff A. Elliott Dept
(b) Address 1129 N. Caroline St.

SEP 8 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5th 1948 at 7 M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1st 1948 to Sept 6 1948, and that I last saw her alive on Sept 5 1948.

Immediate cause of death	Duration
Myocardial insufficiency	6 hrs
Pulmonary edema	12 hrs
Due to arteriosclerosis	long
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 501 N. Calvert St Date signed Sept 8 1948 M. D.

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54R

Registered No. 66627

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 251
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Maisel Ct. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth T. Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Julius Schneider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/22/21

8. AGE: Years	Months	Days	If less than one day
27	2	14	hr. min.

9. Birthplace Penna. Penn. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Orlando Morotte
13. Birthplace Italy

MOTHER
14. Maiden Name Albina Cherroni
15. Birthplace Italy

16 (a) Informant Julius Schneider
(b) Address 2409 Maisel Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/48 (month) (day) (year)
(c) Cemetery or Crematory Holy Cross. [illegible] A.A. Co. Md.

18 (a) Funeral director H. H. Wilson and Son
(b) Address 605 N Calvert St.

19 (Date rec'd by registrar) SEP 8 - 1948 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 6 - 1948, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 - 1948, to 9-6 - 1948, and that I last saw her alive on 9-4 - 1948.

Immediate cause of death Acute cardio respiratory failure — Duration

Due to Intra-ventricular hemorrhage & Increased intra-cranial pressure

Due to Third ventricle tumor

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-24-48

Major findings of operation: Increased intra cranial pressure, hemorrhage

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify in public place)
(e) Means of injury

23. Signature C. D. Thomas Jr. M. D.
Address Mercy Hospital Date signed 9-7-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

Registered No. G66628

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospitals 20-24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 78

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2519 EDMONDSON Ave.
(If rural, give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME WEISHAMPEL, J. HARRY

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NO

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: IDA Litzau

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 2, 1870

8. AGE: Years 78 Months 0 Days 03 If less than one day: hr. min.

9. Birthplace: BALTIMORE
(Town, county, and state)

10. Usual Occupation: PRINTER

11. Industry or business: PRINTING.

FATHER
12. Name: JOHN.
13. Birthplace: OHIO

MOTHER
14. Maiden Name: ADDISON MARY
15. Birthplace: MARYLAND.

16 (a) Informant: Mrs. Ida Weishampel
(b) Address: 2519 Edmondson ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8 1948 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Woodlawn Cem.

18 (a) Funeral director: Geo. L. Berger Jr
(b) Address: 1512 Hollins St

19 (a) SEP 8 1948 (Date rec'd by registrar) Registrar: Washington [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1948, at 10:00 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 14 1948 to Sept 5 1948 and that I last saw h[illegible] alive on 9/5/ 1948.

Immediate cause of death — Duration

Due to Carcinoma of Rectum & Metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/25/48

Major findings of operation: [illegible]

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Robert Haase M. D.
Address Church Home Date signed 9-7-48

VS 133

Correct age is especially important. Physicians: please write causes of death clearly and legibly.

G66629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G66629 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DOA
(c) Hospital or institution: University Hospital 21

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 775 McHenry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Davis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Fritz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18th 1906

8. AGE: Years 42 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name Harry D. Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs William L. Davis
(b) Address 745 McHenry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 09/10/48 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location 3801 Frederick Ave

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St

19 (a) SEP 8 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1948 at 8:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive C-V disease

Due to

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature G. F. Lubrick M.D.
Medical Examiner.
Date signed 9/9/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 666630

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1142 W. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1142 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret E. Wilkens

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frederick

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): Mar 19th 1880

8. AGE: Years: 68 | Months: 5 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Household Work
11. Industry or business: at Home

FATHER
12. Name: Maurice Flynn
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Margaret Dillon
15. Birthplace: Ireland

16 (a) Informant: Miss Celia M. Flynn
(b) Address: 1142 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/48 (month) (day) (year)
(c) Cemetery or crematory: St Peters Cem.
Location: 1300 Maryland Ave

18 (a) Funeral director: John J. Lowanson
(b) Address: 901-03 Hollins St

19 (a) SEP 8 1948 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6th 1948. at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1948. to Sept 6 1948. and that I last saw her alive on Sept 6 1948.

Immediate cause of death	Duration
Cardio Respiratory failure	minutes
Due to Toxemia	3 days
Due to Ruptured Diverticulum DIVERTICULUM	5 days
Other Conditions Hypertensive Cardio vascular disease	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Lommasello
Address 900 N. Lombard St Date signed Sept 7 1948.

123

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

G66631
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 E. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3(a) FULL NAME Albert Joseph Mauser
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife Lennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5-30-1872

8. AGE: Years 76 | Months 3 | Days 8 | If less than one day: hr. | min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Daniel Mauser
13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Haley
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Geo. W. Grimes & Son
(b) Address 511 N. Eutaw St.

19 (Date received by registrar) SEP 8 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1948 at 10.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7-1948 to 9-7-1948 and that I last saw [illegible] alive on 9-7-1948.

Immediate cause of death [illegible] Duration 2 days

Due to Carcinoma of bladder 2 yrs.

Due to METEROSIGMOIDECTOMY, RT

Other Conditions [illegible] 2 mos.

(Include pregnancy within 3 months of death)

Date of operation 7-16-48

Major findings of operation: INOPERABLE [illegible]

of autopsy: Ca [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Willard E. Brown M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

VS 130

G66632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66632

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 ParkHeights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4613 ParkHeights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Gartner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1879

8. AGE: Years	Months	Days	If less than one day
69	5	23	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name M. K.
13. Birthplace Russia

MOTHER
14. Maiden Name Lena
15 Birthplace Russia

16 (a) Informant Benesch Gartner
(b) Address 3737 ParkHeights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Kolker Cong Cemetery
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 N North Ave

19 (a) SEP 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1948 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1948. to Sept 3 1948.
and that I last saw h[illegible] alive on 9/3 1948.

Immediate cause of death: Acute coronary infarction — Duration

Due to ch coronary sclerosis

Due to ch myocardial infarction

Other Conditions ch asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Homstein
Address 2048 Eastdale Date signed 9/8/48 M D

X

G66633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 ✓

Registered No. G66633

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Ruthland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 347 S. Spring Ct (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Felicia Graboski

3 (b) If veteran, name war

3 (c) Social Security Account No. 205-12-6497

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Jesse Graboski
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Jan-2, 1901

8. AGE: Years	Months	Days	If less than one day
47	8	4	..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Martin Binkoski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ? Ladginski
15. Birthplace Unknown

16 (a) Informant Mr. Jesse Graboski
(b) Address 347 Spring Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-48 (month) (day) (year)
(c) Cemetery ~~Cemetery~~ Holy Rosary
Location Baltimore Co. Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 SEP 8 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6 - 1948 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4- 1948 to 9-6 - 1948, and that I last saw h[illegible] alive on 9-6 - 1948.

Immediate cause of death Pyelonephritis — Duration

Due to

Due to

Other Conditions Bronchopneumonia Prostatic hypertrophy - Diabetes
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Sinai Hospital Date signed 9-7-48 M. D.

VS 150

S.E. Harris 133a

66634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G66634 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 N. Strickes St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5339 N. Strickes St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Thomas | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1 1886

8. AGE: Years: 63 | Months: 8 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Philadelphia Pa. (Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Mary Clarkson
(b) Address: 4200 Carlsview Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 6 1948 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location

18 (a) Funeral director: Mrs Katie R Williams
(b) Address: 322 N. Schroeder St

SEP 8 - 1948 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1948; at 1:19 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to Sept 6 1948, and that I last saw h[illegible] alive on Sept 6 1948.

Immediate cause of death: Cerebral Thrombosis
Due to: Hypertension
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 2 weeks, 2 weeks, unknown

Date of operation:
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: Wall, E Town
Address: 4015 Edmondson Date signed 9/7/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 666635

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4001 Springdale Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 67 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4001 Springdale Ave. (If rural give location)
(e) Citizen of foreign country? no Yes or No
If yes, name country

3 (a) FULL NAME Esther Rosabelle Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Frank L. Reed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 10, 1869

8. AGE: Years 79 | Months 6 | Days 26 | If less than one day: hr. min.

9. Birthplace New Orleans, La. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Joseph George Smith

13. Birthplace Bermuda

MOTHER 14. Maiden Name Elizabeth Harnett

15. Birthplace Bermuda

16 (a) Informant Frank L. Reed

(b) Address 4001 Springdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/48 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) SEP 8 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1948, at 9:32 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948 to Sept 5 1948.
and that I last saw h[illegible] alive on Sept 4 1948.

Immediate cause of death: Sarcoma of Transverse Colon — Duration: 6 mo.

Due to

Due to

Other Conditions: Diabetes — Duration: 10 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A Cain M. D.
Address 612 N Gay St Date signed

666636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No. G66636

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 North Caroline Street

(c) Hospital or institution: St. Josephs Hospital 27-4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5413 Hillburn Ave. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME George Arthur Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No. 16-09-8770

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Pearl Sharp Bowen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-9-87

8. AGE: Years 59 Months 2 Days 7 If less than one day hr. min.

9. Birthplace Calvert County, Maryland (Town, county and state)

10. Usual Occupation Insurance Agent

11. Industry or business Balto. Life Ins. Co.

FATHER 12. Name Crumpton D. Bowen

13. Birthplace Maryland

MOTHER 14. Maiden Name Jennie Lee Cusick

15. Birthplace Maryland

16 (a) Informant Mrs. Pearl S. Bowen

(b) Address 5413 Hillburn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Ave.

18 (a) Funeral director Keene Funeral Home

(b) Address 1216 S. Charles St.

19 SEP 8 - 1948 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1948 at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to Sept 6 1948 and that I last saw him alive on Sept 6 1948

Immediate cause of death Ruptured aneurysm of abdominal aorta — Duration

Due to Arterio-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Ruptured aneurysm of aorta

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ray E. Peirson Jr.

Address St. Josephs Hospital Date signed Sept 8/48

VS 150

666637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. 666637

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1315 Presstman St
(c) Hospital or institution: 15-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6-0 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Presstman St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Ashby

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced W.

6 (b) Name of husband or wife John Ashby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 74 Months Days If less than one day hr. min.

9. Birthplace Northumberland Co. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Carter
13. Birthplace Va.

MOTHER
14. Maiden Name Moriah See
15. Birthplace Va.

16 (a) Informant Reuben Parker
(b) Address 1315 Presstman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/45 (month) (day) (year)
(c) Cemetery or crematory Northumberland
Location Northumberland Co. Va.

18 (a) Funeral director Geo. B. Wilson
(b) Address 1303 Presstman St

19 Filed 9-[illegible]-45 (Date received by Registrar) (c) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5- 1945 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10, 1944 to 9-5- 1945 and that I last saw h[illegible] alive on 9-4- 1945

Immediate cause of death: Cardio-renal-vascular disease — Duration: 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Page M.D.
Address 1516 N. Mount St. Date signed 9-6-45

VS 150

Please write plainly, with INDELIBLE INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. 666638

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St. Josephs Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 58 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 244 Spring Court (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Frank A. Hugel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Agness Ompteda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1890

8. AGE: Years	Months	Days	If less than one day
58	0	25	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Linesman Helper

11. Industry or business Gas & Electric Co.

FATHER	12. Name	Not known	
	13. Birthplace	"	"
MOTHER	14. Maiden Name	"	"
	15. Birthplace	"	"

16 (a) Informant Mrs. Robert Schoppert

(b) Address 244 S. Spring Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/48 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 Broadway.

SEP 8 - 1948 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1948 at 1:20 P M

21. I certify that death occurred on the date above stated that I attended deceased from Sept 6 1948 Sept 7 1948 and that I last saw him alive on Sept 6 1948

Immediate cause of death	Duration
Myocardial Failure	
Due to Arterio-sclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature Ray E. Rusow Jr.

Address St. Josephs Hosp. Date signed 9/7/48

PHYSICIAN

Underline the cause to which death should be charged statistically.

666639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 666639

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 S. Clinton Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME: GEORGE HIPPLER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. ?

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife: NONE

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1-8-1889

8. AGE: Years 59 | Months 7 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business ?

FATHER
12. Name IGNATUIS M. HIPPLER
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARGARET HARTMAN
15. Birthplace BALTIMORE

16 (a) Informant ANDREW J. HIPPLER BRO.
(b) Address 3400 WOODSTOCK AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-9-1948 (month, day, year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD.

18 (a) Funeral director LILLY & ZEILER INC.
(b) Address 403 S. WOLFE ST. 31

19 SEP 8-1948 (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5, 1948, at 3:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary artery disease

Due to generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] contributing [ ] cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work?)
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 9-9-48

VS 151

Certificate is especially important. Physicians: please write the causes of death clearly and legibly.

66640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1645

66640 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 740 E. Baltimore St.-Victoria Hotel (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DONALD PENNEY

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	MARRIED

6 (b) Name of husband or wife GLADYS F. PENNEY
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) AUG. 14, 1890

8. AGE: Years	Months	Days	If less than one day
58	-	21	hr. min

9. Birthplace NEW YORK (Town, county, and state)

10. Usual Occupation MERCHANT SEAMAN

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant GLADYS F. PENNEY R.F.D.
(b) Address WILLOWYVILLE, N.Y. #1

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9 8 48 (month) (day) (year)
(c) Cemetery or crematory F.G. Miller & Son.
Location Candor, N.Y.

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto. 31. Md

19 SEP 8 - 1948 (Date rec'd by registrar) (Signature) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 1948, at 12:05 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage

Due to self-inflicted wound of neck

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-3-48 at 11:30 A. M.?
(b) Where did injury occur? 740 E. Balto. St.
(c) Did injury occur at home, on farm, industrial place, in public place? Hotel (While at work) No
(d) Means of injury Sharp Instrument

23. Signature Earl L. Rose M.D. (Medical Examiner)
Date signed 9-4-48

correct age is especially important: Physicians: please write the causes of death clearly and legibly.

666641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

666641 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 10+
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Ensor Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT BRUNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 35 | Months | Days | If less than one day: hr. min.

9. Birthplace Richmond Va (Town, county, and state)

10. Usual Occupation Salon

11. Industry or business

FATHER 12. Name William Brunson

13. Birthplace S. C.

MOTHER 14. Maiden Name Daisy Holt

15. Birthplace Halifax Va

16 (a) Informant Sallie Miller

(b) Address 214 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 8, 48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Brooklyn, Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1710 Blankley Ave

19 (a) SEP 8 - 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6, 1948, at 1.45 P M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Stab wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following.

(a) Date of injury 9-6-48 at approx. 1.00 p. M.

(b) Where did injury occur? Found in front of 148 East St.

(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no

(d) Means of injury sharp instrument

23. Signature Earl L Roy M.D. (Medical Examiner)

Date signed September 7, 1948

VS 151

X

666642 B.D. 48-21222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1600 V. 666642 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hosp
(c) Hospital or institution:
Bon Secours Hosp. Balto
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 36 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County B
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Bon Secours Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Greenfelder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/4/48

8. AGE: Years | Months | Days: 1 | If less than one day: 30 hr. 30 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm. William Greenfelder
13. Birthplace Balto Md

MOTHER 14. Maiden Name Norma Heckman
15. Birthplace Balto Md

16 (a) Informant Mrs. Wm Greenfelder
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8 48 (month) (day) (year)
(c) Cemetery or crematory Emmanuel Cem
Location Druid Hill Ave

18 (a) Funeral director L. HECKMAN & SON
(b) Address 6067 Harford Rd

SEP 8 - (Date rec'd by registrar) (Funeral Director)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1948 at 4:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1948 to Sept 5 1948 and that I last saw h alive on Sept 5 1948

Immediate cause of death: Respiratory failure — Duration

Due to: Cerebral injury

Due to: Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Bon Secours Hosp Date signed 9/5/48

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X1

666643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 666643

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4717 Fernhill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4717 Fernhill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary F. Keigler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William H. Keigler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov 23 1867

8. AGE: Years: 80 | Months: 9 | Days: 15 | If less than one day: 14 hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Charles W. Kerr
13. Birthplace: Germany

MOTHER
14. Maiden Name: Caroline Glaeser
15. Birthplace: Germany

16 (a) Informant: Dorothy M. Keigler
(b) Address: 4717 Fernhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 10 1948 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem
Location: Baltimore Md

18 (a) Funeral director: E. Fillis Taylor and
(b) Address: 4510 Liberty Heights Ave

19 (a) SEP 8 1948 (Date received by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7th 1948, at 05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to Sept 7 1948 and that I last saw h M alive on Sept 7 19

Immediate cause of death: Diabetes mellitus

Due to: Arterio sclerosis Hypertension

Due to: ff

Other Conditions: Secondary anemia

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 24 hr 30
5 yrs
3 yrs
6 mo

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Hallie D Hubbard M. D.
Address Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 153

G66647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66647 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Lansdown (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 3rd. Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE Phillip WEBER

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 216-20-2351

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Roberta (Lorenz) Weber

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1883

8. AGE: Years 65 | Months 0 | Days 10 | If less than one day / hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business: Westinghouse

FATHER 12. Name: William Weber

13. Birthplace: Baltimore, Maryland

MOTHER 14. Maiden Name: Christina Beiler

15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Roberta L. Weber - widow

(b) Address: 113 - 3rd. Ave. Lansdowne

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9 /48 (month) (day) (year)

(c) Cemetery or crematory: Baltimore National

Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.

(b) Address: NORTH AVE. & BROADWAY

SEP 8 - 1948 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5, 1948, at 3.55 PM

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Medical Examiner M.D.

Date signed September 6, 1948

Cause of death is especially important. Physicians: please write the causes of death clearly and legibly. Use of abbreviations or arbitrary symbols not permitted.

G66645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66645

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 27 N. Carey St

(c) Hospital or institution Good Samaritan Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 444 Fossett St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Martha A. Kraft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
Female	White	Widowed

6 (b) Name of husband or ~~wife~~ Philip Kraft

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10th 1868

8. AGE: Years	Months	Days	If less than one day
79	11	26	hr. min.

9. Birthplace Westminster, Md

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER

12. Name John Zentz

13. Birthplace Md

MOTHER

14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Mrs Elva Harden

(b) Address 2076 Druid Park Drive

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/8/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Woodlawn

Location Md.

18 (a) Funeral director William Cook Jr

(b) Address 1217 St. Paul St.

SEP 8 - 1948

(Date rec'd by registrar)

(b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6th 1948 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1948 to Sept 6 1948 and that I last saw her alive on Sept 2 1948.

Immediate cause of death	Duration
Arteriosclerotic Chronic	Unknown
Due to Chronic Bronchitis	
Due to Emphysema	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Palmer Gordon M. D.

Address 1012 Eutaw Pl Date signed 9/8/48

VS 150

G66646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

✓ G66646 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N. WASHINGTON ST (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME CATHARINE ROSENTHAL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife ROBERT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-15-1916

8. AGE: Years 32 | Months 7 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace MARYLAND. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name JOSEPH WINGDIG
13. Birthplace Md.

MOTHER 14. Maiden Name ELLA PONTY
15 Birthplace Md.

16 (a) Informant:
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Wm. Cook Inc
(b) Address 1213 St. Paul St. Huntington Williamsport, Md.

SEP 8 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 1948. to Sept. 7 1948. and that I last saw her alive on Sept. 7 1948.

Immediate cause of death Fracture, base skull. Left Hemorrhage, intracranial — Duration

Due to Fall from 2nd story

Due to of house.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: 9-7-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 6/4
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9-7-48 at 2:00 P.M.
(c) Where did injury occur? Balt. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? (Specify)
(e) Means of injury Fall from loss balance second floor

23. Signature Lower A. Gustafson

Address Johns Hopkins Hospital Date signed 9-7-48

VS 150 Medical Examiner Cont - Released to Hospital Asst. M.E.

66647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 144c

66647

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanora Brookes

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-14-7206

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married

6 (b) Name of husband or wife Robert -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1912.

8. AGE: Years	Months	Days	If less than one day
36	3	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Cormick
13. Birthplace Cambridge Md

MOTHER
14. Maiden Name Helen Higgs
15. Birthplace Cambridge Md

Records -

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Robert L Williams
(b) Address 1515 McElderry St

19 (a) 9/4/48 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1948 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5 1948 to Sept 5 1948 and that I last saw him alive on Sept 5 1948

Immediate cause of death Aspiration of blood & vomitus, associated with hemorrhagic phenomenon

Due to Hypoprothrombinemia

Due to Hepatitis

Other Conditions Pregnancy, term, undelivered. Extradural hemorrhage (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Hepatitis, extradural hemorrhage

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Valbuena M. D.
Address JOHNS HOPKINS HOSPITAL Date signed

To be approved by the Med & Chirurg Faculty

Stevenson, M.D.

G66648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G66648

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2792 W. North Ave

(c) Hospital or institution:

15 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2792 W. North Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Francis Caple

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-16-6177

4. Sex: M.

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sallie F. Caple

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28th, 1862

8. AGE: Years 86 | Months 4 | Days 9 | If less than one day: hr. min.

9. Birthplace Finksburg, Carroll Co Md.

(Town, county, and state)

10. Usual Occupation Contractor (Retired)

11. Industry or business

FATHER

12. Name Joseph C. Caple

13. Birthplace Carroll Co., Md

MOTHER

14. Maiden Name Rebecca Shilling

15. Birthplace Carroll Co. Md.

16 (a) Informant Miss Mae Caple

(b) Address 2792 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10-1948 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto, Md

18 (a) Funeral director Bertram L. Gore

(b) Address 2224 N. Charles St

19 (a) 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep't 7th, 1948 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1947 to Sept 7 1948, and that I last saw h[illegible] alive on Sept 5 1948.

Immediate cause of death: a Arteriosclerosis — Duration: 10 Yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address Date signed 9/8/48

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G66649

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N. Poppleton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY TAYLOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Elizabeth Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): October 1, 1893.

8. AGE: Years: 54 | Months: 11 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Huntington W. Virginia
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Henry Taylor.
13. Birthplace: W. Virginia

MOTHER
14. Maiden Name: Unknown.
15. Birthplace

16 (a) Informant: Edith Thompson
(b) Address: 22 N. Poppleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 10, 1948.

(c) Cemetery or crematory: Mt. Calvary.
Location

18 (a) Funeral director: Mr. Katie D. Williams
(b) Address: 2220 Pennsylvania Ave.

8 (a) 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1948 7:30 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl K. Rose M.D.
Medical Examiner

Date signed 9-[illegible]-48

VS 151

Cause of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

G66650
GM. 115723

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G66650
Registered No. 136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. High ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bertha Buck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife George Buck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13 1930

8. AGE: Years 18 Months 3 Days 24 If less than one day hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Brown Jackson (Step Father)
13. Birthplace MD.

MOTHER
14. Maiden Name Emily Ryan
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11, 1948. (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie B. Williams
(b) Address 322 Schroeder Sts.

18 (c) 1948 (Date) Huntington Williams, M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 6- 1948 at 9.50 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 12- 6- 1947 to 9- 6- 1948, and that I last saw her alive on 9- 6- 1948

Immediate cause of death For advanced Pulmonary Tuberculosis with cavitation

Duration 3½ yrs.

Due to

Due to

Other Conditions Tuberculous Laryngitis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature Margaret A. Moran M. D.
Address Baltimore City Hosp. Date signed 9-7-48

VS 150

Copy or tape is especially important. Physicians please write the causes of death clearly and legibly.

666651

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 307

666651
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 W. Mulberry St.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State U.S. (b) County
(c) City or town Balto
(If outside city or town limits, write LITERAL and give town)
(d) Street No. 701 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Nannie Gray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 1894

8. AGE: Years 54 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Greenville S. C.
(Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER
12. Name Willis Gray
13. Birthplace Greenville S.C.

MOTHER
14. Maiden Name Ward
15. Birthplace Greenville S.C.

16 (a) Informant Rachel Bogden
(b) Address 307 Myrtle Ave.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Sept 8, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie P. Williams
(b) Address 3226 Schroeder St

19 (a) 1948 (Registered by registrar) Washington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1948, at 12 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 1948 to 9/5 1948, and that I last saw him alive on 8/30 1948

Immediate cause of death Hemorrhage — Duration 4 mos.

Due to Ruptured Aortic Aneurysm

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury

23. Signature J. Kurtz Grant

Address 601 N. Carroll St Date signed 9/8/48 M

VS 150

G66652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G66652 Registered No. 156 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Md. University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Havre De Grace (If outside city or town limits, write RURAL and give town)
(d) Street No. STAR Route Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Leroy Durbin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1945

8. AGE: Years 3 | Months — | Days 30 | If less than one day — hr. — min.

9. Birthplace Havre de Grace, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Wm. A. Durbin
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Mary Cronfsell
15. Birthplace Md.

16 (a) Informant Mr. Annie Mary Durbin
(b) Address Havre de Grace Md. Star Route

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory St. James
Location Havre de Grace Md.

18 (a) Funeral director J. Madison Mitchell
(b) Address Havre de Grace, Md.

19 (a) 9-8-1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8 1948, at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 1948 to Sept 8, 1948, and that I last saw him alive on Sept 8, 1948

Immediate cause of death Respiratory failure

Due to Hyperpyrexia with convulsions

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 48 hours

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify in each case)
(e) Means of injury

23. Signature William J. Halloway M.D.
Address University Hospital Baltimore, Md. Date signed 9-8-48

Surgery age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

666653 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 526 N. Clinton St., (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Charles Arnold Moser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth H. Moser (nee Heim)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-13-91

8. AGE: Years 56 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired - Baltimore Transit

11. Industry or business

FATHER
12. Name Charles Moser
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Pauline Schlaak
15 Birthplace Germany

16 (a) Informant Mrs. Elizabeth Heim Moser
(b) Address 2228 E. Jefferson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Taylor Ave., Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) [illegible] (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1948, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1- 1948 to 9-5 1948, and that I last saw him alive on 9-5 1948.

Immediate cause of death Pulmonary Congestion — Duration

Due to Arteriosclerotic Heart Disease - Left Heart Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Rehfuss, M.D.
Address St. Joseph's Date signed 9-5-48

VS 150

Please answer all questions. Answer each question as exactly as possible. Physicians: please write the causes of death clearly and legibly.

666654

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

666654 — 1579

Registered No. 666654

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State WEST VIR. (b) County
(c) City or town RANSON (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BOY GRAPES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-28-1948

8. AGE: Years — | Months — | Days 10 | If less than one day hr. min.

9. Birthplace WEST VIRGINIA (Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business

FATHER
12. Name WALDO GRAPES
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden Name JUNE H. MERCER
15. Birthplace WEST VIRGINIA

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Edgehill Cemetery
Location Charlestown W. Va.

18 (a) Funeral director Wm. J. Tiekner & Sons
(b) Address No. & Pa. Aves. Balt. 17, Md

19 (a) 1948 (Date rec'd by Registrar) Registrar

SEP 8 Washington Co. Health Dept. Hagerstown, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 7 1948 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1948 to 9-7 1948.
and that I last saw him alive on 9-7 1948.

Immediate cause of death	Duration
Pneumonia	
Due to Post-operative Tracheo-esophageal fistula & esophageal atresia.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9/2/48
Major findings of operation: Esophageal atresia
of autopsy: Pneumonia, massive

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton Wentraub M. D.
Address Johns Hopkins Date signed 9/8/48

66655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66655

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore ([redacted] or days) 9

2. USUAL RESIDENCE OF DECEASED:
(a) State Ind (b) County St. Marys
(c) City or town Mechanicsville (If outside city or town limits, write RURAL and give town)
(d) Street No. rural (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MR VERNON KURTZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs Madeline Kurtz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-14-95

8. AGE: Years	Months	Days	If less than one day
53	9	26	25 hr. min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Albert Leon Kurtz
13. Birthplace Illinois

MOTHER
14. Maiden Name Gertrude Abercrombie
15 Birthplace Ohio

16 (a) Informant wife
(b) Address Rural

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington Va.

18 (a) Funeral director W. C. Keatinge Sons
(b) Address Leonardtown, Md

19 Filed Sep 9 1948 (b) Courtney for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8 1948, at 3:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31-1948, to 9-8-1948, and that I last saw him alive on 9-8-1948.

Immediate cause of death	Duration
Myocardial failure, acute	[redacted]
Due to Myocardial infarction	5 days
Due to Coronary atherosclerosis	

Other Conditions Hypertension, Pulmonary thrombosis, left, Congestion, (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph [illegible] M.D.
Address Mercy Hospital Date signed 9-8-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666656 A3-116782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. 666656

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claude David Glenn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) October 18-1947

8. AGE: Years	Months	Days	If less than one day
10	11	7	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Glenn
13. Birthplace S.C.

MOTHER 14. Maiden Name Geraldine Carty
15. Birthplace Norwich, Conn

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 31 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 31 1948 (Date rec'd by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25- 1948 at 5.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21- 1948 to 8-25- 1948 and that I last saw him alive on 8-25- 1948

	Duration
Immediate cause of death: Respiratory failure	
Due to: Sclerocystadenoma	9 months
Due to: Endothelial hemangioma	2 months
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2- Feb. 1948

Major findings of operation: Endothelial Hemangioma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address BCH Date signed Aug 27, 48 M. D.

VS 153

G66657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC-48-19007 159

Registered No. G66657

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs 6 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 hrs. 6 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 434 S. Ogiole, Md.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Charles Scott

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-21-48

8. AGE: Years	Months	Days	If less than one day
			10 hr. 6 min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Harris Scott
13. Birthplace Baltimore Maryland.

MOTHER
14. Maiden Name Dologes Cagdarelli
15. Birthplace Baltimore Maryland.

16 (a) Informant Mrs. Dologes Scott
(b) Address 434 S. Ogiole Baltimore.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location AUG 27 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) 8-24-1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22 1948, at 7 40 M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-21 1948 to 8-22 1948, and that I last saw him alive on 8-21 1948.

Immediate cause of death	Duration
Anoxia	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl Schumack M. D.
Address 842 E. Eutaw Date signed 8-24-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 666658

666658

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cold Spring Cemetery
(c) Hospital or institution: Home 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Cold Spring Lane
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert P Holbert

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Alice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22 1879

8. AGE: Years 69 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Balto Co Md (Town, county, and state)

10. Usual Occupation Balto Fireman

11. Industry or business

FATHER 12. Name Samuel Holbert
13. Birthplace Md

MOTHER 14. Maiden Name Sarah —
15. Birthplace Md

16 (a) Informant Jeneva Holbert
(b) Address 1226 W 36 St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10 48 (month) (day) (year)
(c) Cemetery or crematory Cremo Chapel
Location Green Spring Ave

18 (a) Funeral director Edmund Foulger
(b) Address 2359 Wash Blvd

19 SEP 9 1948 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1948 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to Sept 8 1948 and that I last saw h alive on Sept 7 1948

Immediate cause of death 1 Generalized Arteriosclerosis | Duration 10 yrs
2 Coronary Arteriosclerosis Heart Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R Klemm M. D.
Address 3813 Edmondson Ave Date signed 9/9/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Hospital Disposal Telegram

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 666659

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Anne Arundel

(c) City or town Glenburnie (If outside city or town limits, write RURAL and give town)

(d) Street No. 1204 Usted Road (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Gil (B) Small

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age, years

7. Birth date of deceased (mo., day, yr) 9/2/48

8. AGE: Years | Months | Days: 1 | If less than one day: 31 hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Small

FATHER 13. Birthplace

MOTHER 14. Maiden Name Kathryn

MOTHER 15. Birthplace

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Hope Memorial

18 (a) Funeral director

(b) Address

19 SEP 9 - 1948 (Date rec'd by registrar) (b) Huntington Williamsport Registrar

MEDICAL CERTIFICATION 25-A

20. DATE OF DEATH Sept. 3 1948, at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 , and that I last saw h alive on 19 .

Immediate cause of death

Prematurity

Due to

Due to

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E E Hopkins M. D.

Address JOHNS HOPKINS HOSPITAL Date signed 9-4-48

VS 150

666660

Hospital Telegram

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 159

Nursery Disposal

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Glenn Burnie (If outside city or town limits, write RURAL and give town)

(d) Street No. 1204 Osted Road (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl "a" Small

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-2-48

8. AGE: Years | Months | Days | If less than one day

1 | | | 6 hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name James Small

13. Birthplace ?

MOTHER

14. Maiden Name Kathryn ?

15. Birthplace ?

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Loch Raven

Location Baltimore

18 (a) Funeral director

(b) Address

19 SEP 9 - 1948 Huntington Williamsport, Md.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3- 1948, at 5:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1948 to 9-3 1948, and that I last saw her alive on 9-3 1948.

Immediate cause of death Prematurity

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature C. C. Hopkins M. D.

Address JOHNS HOPKINS HOSPITAL Date signed 9-4-48

VS 150

X

666661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. 666661

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5146 Stafford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Beatrice B. Phillips

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife David S. Phillips

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 4, 1896

8. AGE: Years 52 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Brown
13. Birthplace England

MOTHER
14. Maiden Name Emma ?
15. Birthplace Ireland

16 (a) Informant Mr. David S. Phillips
(b) Address 5146 Stafford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address 1945 Balto., Md.

19 (a) SEP 9 (Date rec'd by registrar) (b) Huntington for Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8 1948, at 7.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1948 to Sept 8 1948, and that I last saw her alive on Sept 7 1948.

Immediate cause of death Myocardial failure, acute

Due to ventricular fibrillation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug. 27, '48

Major findings of operation: Fibroids uterus chronic cervicitis & cervical ca.

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred K. McClements Jr. M. D.
Address Community Hosp. Date signed 9/8/48

VS 150

X

166662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

Registered No. 166662

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3545 Chestnut Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES R. HANCOCK, Sr.

3 (b) If veteran, name war: World War #II

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife: Amelia E. Trainor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1897

8. AGE: Years	Months	Days	If less than one day
51	4	4	hr. min.

9. Birthplace: St. Mary's Co., Md. (Town, county, and state)
10. Usual Occupation: Credit Manager
11. Industry or business: Sandlers Dept. Store

FATHER
12. Name: Thos. J. Hancock
13. Birthplace: St. Mary Co., Md.

MOTHER
14. Maiden Name: Martha E. Robinson
15. Birthplace: St. Mary Co., Md.

16 (a) Informant: Mr. James R. Hancock, Jr.
(b) Address: 327 Upland Rd., Pikesville, 8, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery or crematory: Balto. National Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: 1918 Baltimore, Md.

19 (a) SEP 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8 1948, at 11:30 AM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral wound of brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-8-48 at M.
(b) Where did injury occur? 3545 Chestnut Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Firearms

23. Signature Howard J. Masters M.D. Medical Examiner.
Date signed 9-8-48

666663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

666663 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5203 Bosworth Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5203 Bosworth Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUSTA C. PFEIL

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1859

8. AGE: Years 89 | Months 1 | Days 29 | If less than one day: hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name August Pfeil

13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Heinzerling

15. Birthplace Germany

16 (a) Informant Mrs. Emma H. Orr, niece

(b) Address 5203 Bosworth Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) SEP 9 - 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1948 at 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1948 to Sept 8 1948.
and that I last saw her alive on Sept 1 1948

Immediate cause of death
(a) Cerebral Vascular accident
Due to
Due to old age

Duration 14 days

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide /
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Pearce M.D.
Address 3701 Eastern Ave. Date signed 9/9/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G66664

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2d N. Patterson Pk. Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2d N. Patterson Pk. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R. Baker (Conway)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Charles Baker
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Feb. 14 - 1887

8. AGE: Years	Months	Days	If less than one day: hr.	min.
61	6	23		

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business —

FATHER
12. Name Ignatius Yoss
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Myers.
15. Birthplace Balto. Md.

16 (a) Informant Frank (Bill Jones)
(b) Address 2d N. Patterson Pk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10, 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Dayton Hill Rd.

18 (a) Funeral director John J Connolly
(b) Address 1108 Eastern Ave.

19 (a) SEP 9 - 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1948 at 5 30 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 27 1944 to Sept 7 1948 and that I last saw h alive on Sept 7 1948.

Immediate cause of death	Duration
Coronal Thrombosis	4 yrs
Hypertension	
Due to Arteriosclerosis	1944
Kidney Disease	
Due to Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H J Feldmann M. D.
Address 3426 Bank St. Date signed 7/7/49

VS, 150

666665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. 666665

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 North Rose St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMIL [illegible]NBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 60 | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical Service SEP 1 1948

18 (a) Funeral director Coroner of Md.

(b) Address

19 SEP 9 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, 8.45p.M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, feel that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulation due to hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing [ ] cause of death, fill in the following:

(a) Date of injury 8-17-48 at approx. 8.00PM.

(b) Where did injury occur? 1918 N. Rose St.

(c) Did injury occur at home, on farm, industrial place, in public place? home (While at work) no

(d) Means of injury hanged self by rope from banister

23. Signature [signature] M.D. Medical Examiner

Date signed August 18, 1948

Please answer all questions, especially important. Physicians: please write the causes of death clearly and legibly.

66666 BC-48-1723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 66666

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day 1 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 N. Dorcas (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lorraine Francis Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Negro | 6 (c) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8 6 48

8. AGE: Years 1 | Months | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation New Born

11. Industry or business

FATHER
12. Name Leroy Sims
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Frances Martin
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Frances Martin
(b) Address 507 N. Dorcas St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 2 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 9 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/48 at 4:55 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 8/14/48 to 8/20/48 and that I last saw h alive on 8/20/48

Immediate cause of death Respiratory failure — Duration

Due to Resp. Distress

Due to Pneumonia & Prematurity

Other Conditions Wgt. 7 lbs. 13 oz.
(Include pregnancy within three months of death)

Date of operation Not

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. H. Bradburn, M.D.
Address Provident Hosp. Date signed 8/20/48

VS 150

666667 48-18340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

666667 ✓ Registered No. 157E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 N. Chapel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carolann Price

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/27/48

8. AGE: Years 0 | Months 0 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Albert Price
13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Mildred Elizabeth Metzgar
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 2 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

SEP 9 - 1948 (Date rec'd by Registrar) (b)

VS 133

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1948, at 10 17 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27/48 to 8/29 1948 and that I last saw [illegible] alive on 8/29 1948

Immediate cause of death: Cardiorespiratory failure

Due to: Partial atelectasis of new born.

Due to:

Other Conditions: (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Congenital laryngeal stridor

of autopsy: Elementary mitral stenosis

Duration: 48 hrs.

PHYSICIAN
Underline the cause to which death should be charged [illegible]

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. R. Jones Jr.
Address Maryland General Hosp Balto Md Date signed 9/1/48

666668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. 666668

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Savage St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LEO PAPLINSKI (PEPLINSKI) (djm)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Josephine Paplinski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Nanticoke, Pa. (Town, county, and state)

10. Usual Occupation Maintenance Dept.

11. Industry or business Eastern Stainless Steel

MOTHER / FATHER

12. Name Michael Paplinski

13. Birthplace Germany

14. Maiden Name Mary Baudurski

15. Birthplace Northumberland, Pa.

16 (a) Informant D. A. Drapiewski & Son
(b) Address 22 W. Green St., Nanticoke, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery or crematory St. Francis
Location Nanticoke, Pa.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 9 - 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8, 1948, at 2.20p M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Aortic stenosis

Chronic vegetations; chronic valvulitis

Hypertrophy of the heart; Edema and

~~Due to~~ congestion of the lungs; Moderate

arteriosclerosis including coronary arteries.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Davis M.D. Medical Examiner.
Date signed September 9, 1948

VS 151

G66669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

195E

Registered No. G66669

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 27-1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city limits, write RURAL and give town)
(d) Street No. 301 Willow Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME Charles RAZGAITIS

3 (b) If veteran, name war: Yes

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 38 | Months | Days | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Cable Sealer

11. Industry or business

FATHER 12. Name: George Razgaitis

13. Birthplace: Lith.

MOTHER 14. Maiden Name: Pauline

15. Birthplace: Lith

16 (a) Informant: Pauline Razgaitis

(b) Address: 531 Willow ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10-48

(c) Cemetery or crematory: Holy Redeemer Cem.

Location: Belair Rd.

18 (a) Funeral director: Joseph Nasiakos

(b) Address: 602 Washington Blvd

19 (a) SEP 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1948, at 3:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Amputation right arm

Fractured ribs.

~~Due to~~ Fractured right ankle.

Infacts of Kidneys.

~~Other Conditions~~ Edema of lungs.

Anasarca.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-30-48 at ? M.

(b) Where did injury occur? Western Electric Co. Point Breeze, Balto. Co.

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes

(d) Means of injury: Large spool of steel wire fell on him

23. Signature: George G. Merrill M.D. Medical Examiner.

Date signed 9/7/48

VS 151

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66670
461237

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66670
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Madison, Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Douglas.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mamie Douglas
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2-19-72
8. AGE: Years 76 | Months 6 | Days 16 | If less than one day hr. min.
9. Birthplace Ill (Town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business

FATHER
12. Name Arnold Douglas
13. Birthplace Tenn.

MOTHER
14. Maiden Name Henrietta Samuels
15. Birthplace S. C.

16 (a) Informant: records
(b) Address JOHNS HOPKINS HOSPITAL.

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof Sept. 10 1948 (month) (day) (year)
(c) Cemetery or crematory Lebanon Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Geo. A. Holland
(b) Address 68 Druid Hill Ave.

19 (a) 1948 (Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1948 at 11 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26- 1948 to 9-5- 1948 and that I last saw him alive on 9-5- 1948

Immediate cause of death Pontine palsy — Duration 12 hrs.

Due to Hypertensive C.V. disease + cerebral accident — 2-3 yrs. 15 days.

Due to

Other Conditions Carcinoma of prostate + metastases, inoperable — 1 1/2 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of prostate

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Willard E. Goodwin M. D.
Address JOHNS HOPKINS HOSPITAL Date signed 9-7-48

VS 150

666671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

Registered No. 666671

Print clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2804 W. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2804 W. Lafayette Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lobe Schneider

3 (b) If veteran, name war: No

3 (c) Social Security Account No. No

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Lillian T. Schneider

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr) Jan 5, 1886

8. AGE: Years 62 | Months 8 | Days 3 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Interior Renovator

11. Industry or business: Self

FATHER
12. Name: Lobe Schneider
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Christin ?
15. Birthplace: Maryland

16 (a) Informant: Mrs. Lillian Schneider
(b) Address: 2804 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/48 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: John T. Stansbury
(b) Address: 2700 Edmondson Ave.

19 (a) Received (b) Registrar

SEP 9 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 th. 1948 at 1.30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1 1947 to Sept 8 1948. and that I last saw him alive on Sept 8 1948.

Immediate cause of death: Myocardial insufficiency — Duration: 1 week

Due to: Generalized carcinomatosis — Duration:

Due to: Carcinoma of the esophagus — Duration: 10 months

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation March 1st 1948

Major findings of operation: Carcinoma of esophagus.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Mitchell M. D.

Address 2901 Edmondson Ave Date signed Sept 9 1948

VS 150

666672 DC-48-880 BALTIMORE CITY HEALTH DEPARTMENT ✓ 666672

CERTIFICATE OF DEATH 160a

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Ave
(c) Hospital or institution: Univ. Hosp. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 Woodview Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Simmons A.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23, 1948

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Univ. Hosp. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name James W. Simmons

13. Birthplace ? S.C.

MOTHER 14. Maiden Name Sallie Lomax

15. Birthplace Greenville S.C.

16 (a) Informant Mother

(b) Address Same

17 (a) Gift Disposal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 2 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) SEP 9 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 1948, at 12 15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1948 to Aug 25 1948, and that I last saw h[illegible] alive on 8-23 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Intra-cranial Hemorrhage	
Due to Pre-maturity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. G. Smedley Jr. M. D.

Address Univ. Hosp. Balt. Date signed 8-25-48

VS 150

666673 C-48-181 55

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 666673

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Taylor, Baby Boy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 20, '48

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Clarence Taylor

13. Birthplace

MOTHER 14. Maiden Name Beatrice

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 2 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) SEP 9 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1948, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1948 to Aug 26 1948 and that I last saw him alive on Aug 26 1948.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, or industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred R. McDaniel Jr. M. D.

Address University Hosp. Date signed Aug

VS 150

66674 BC - 48-1856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66674
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 McKean Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war — (c) Social Security Account No.

4. Sex M | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/27/48

8. AGE: Years | Months | Days | If less than one day 14 hr. min

9. Birthplace Univ. Hosp., Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name James Williams
13. Birthplace N.C.

MOTHER 14. Maiden Name Naomi Williams
15. Birthplace N.C.

16. (a) Informant Same as 14
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School SEP 2 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 9 1948 Washington Williams M.D.
(Signature of undertaker or agent)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28/48 at 3:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27/1948 to 8/28/48
and that I last saw him alive on 8/25 1948

Immediate cause of death Asphyxia.

Due to Aspiration Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Shuel, Jr. M. D.

Address [illegible] Date signed 9/1/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

366675 BC-48-1908 S

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. 366675

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address So. Balt. Gen. Hosp.
(c) Hospital or institution: 24-4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15hr 20min. 1822 Balt St
(e) Length of stay in Baltimore (yrs., mos., or days) 15hr 20min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. So. Balt. Gen. Hosp. (If rural, give R.F.D. number)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Son of Clarence & Geraldine Neal - 13

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/5/48

8. AGE: Years | Months | Days | If less than one day 15 hr. 20 min.

9. Birthplace So. Balt. Gen. Hosp. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Clarence
13. Birthplace Baltimore

MOTHER 14. Maiden Name Geraldine Blose
15. Birthplace Baltimore

16 (a) Informant Geraldine Neal
(b) Address Baltimore

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location SEP 8 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6/48 1948 at 2:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 1948 to 9/6 1948, and that I last saw him alive on 9/6 1948.

Immediate cause of death Atelectasis — Duration 15 hr. 20 min.

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R. MacDonald M. D.
Address 1213 Light St Date signed 9-6-48

VS 153

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666676 BC-48-12857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 666676

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 18 1
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city limits, give township)
(d) Street No. University Hospital (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-3-48

8. AGE: Years | Months | Days 2 1 | If less than one day hr. min.

9. Birthplace University Hospital (town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Williams
13. Birthplace Windsor N. C.

MOTHER
14. Maiden Name Eugenia Simons
15. Birthplace Colerain N. C.

16 (a) Informant Attendant
(b) Address University Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location [illegible] SEP 8 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 SEP 9 1948 (Date received by local registrar) (b) [illegible] Registrar

VS 150 City Disposal

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 1948 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from September 3 1948, to Sept 4 1948, and that I last saw him alive on Sept 4 1948.

Immediate cause of death	Duration
Prematurity	
Due to Toxemia of Pregnancy Pre-Eclampsia	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. E. Laborn M. D.
Address University Hospital Date signed 9-8-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666677 BC-48-07257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 158

Registered No. 666677

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Aliceanna Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD SISK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months: 4 | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 8 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 9 - 1948 (Date rec'd by registrar) (b) [illegible], M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at 5:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Malnutrition

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work)
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8-28-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66678 BC-18-1602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G66678 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1875 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Frederick

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/8/48

8. AGE: Years | Months | Days 2 | If less than one day hr min

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Frederick
13. Birthplace Lynchburg, Va.

MOTHER
14. Maiden Name Alicia Sturgeon
15. Birthplace Richmond Co. Va.

16 (a) Informant Mrs. Alicia Frederick
(b) Address 1875 E. Chase St., Balto., Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 2 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 9 - 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1/48 at 9 55 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31/48 to 9/1/48; and that I last saw him alive on 9/1/48.

Immediate cause of death: Respiratory failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include conditions contributing to death but not related to cause given)

Date of operation None

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. H. Sudbeck

Address 1200 Hoy. Date signed 9/2/48

666679 — 48-196 K3 — ✓ — 666679

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 666679

CERTIFICATE OF DEATH 161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts.
(c) Hospital or institution: Hosp. for Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 + day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 Woodbourne Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hedden

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1948

8. AGE: Years | Months | Days | If less than one day: 1 hr. 21 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James Alver Hedden
13. Birthplace Jamesonville, New Jersey

MOTHER
14. Maiden Name Sadie Marguerite Patton
15. Birthplace Hatfield, Pennsylvania

16 (a) Informant Mrs. James A. Hedden
(b) Address 2004 Woodbourne Ave, Balto.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School SEP 2 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (SEP 9 - 1948) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1948 at 4 5½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1-1948 to 9-1-1948. and that I last saw him alive on 9-1-1948.

Immediate cause of death Anaemia — Duration

Due to Congenital atelectasis

Due to

Other Conditions maternal — partial premature separation of placenta
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. G. Spencer M. D.
Address Hosp. for Women of Md. Date signed 9-2-48

VS 130

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66680 BC-48-1908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G66680

Please answer all questions as completely as possible. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address So. Balt. Gen. Hosp.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hr 20mm

(e) Length of stay in Baltimore (yrs., mos., or days) 4hr. 20mm

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5 S. Bal. Gen. Hospital

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Son of Clarence & Geraldine Neal - A.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9 | 5 | 48

8. AGE: Years | Months | Days | If less than one day 4 hr 20 min.

9. Birthplace So. Balt. Gen. Hosp. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Clarence

13. Birthplace Baltimore

MOTHER 14. Maiden Name Geraldine Bloom

15. Birthplace Baltimore

16 (a) Informant Geraldine Neal

(b) Address Baltimore

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Baltimore City Health Dept. SEP 8 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 9 - 1948 (Date rec'd by registrar) Certificate for Miscarriage

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 | 5 | 48 (month) (day) (year) at 3:20 P.M.

21. I certify that death occurred on the date stated, that I attended deceased from 10:59 A.M. 9/5/48 to 3:20 P.M. 9/5/48 and that I last saw him alive on 9/5/48

Immediate cause of death (Interfering Prematurity)

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration: 4 hr. 20 mm

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles B. Macdonald

Address 213 Light St. Date signed 9-5-48

VS 150

G66681

DS-

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66681

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 10, 1879

8. AGE: Years 68 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benjamin (D)
13. Birthplace ?

MOTHER
14. Maiden Name Frances McKin
15. Birthplace ?

16 (a) Informant RECORDS Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location [illegible] SEP 8 1948

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 SEP 9 - 1948 (Date rec'd by registrar) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 1948, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 1948 to 8-26 1948
and that I last saw him alive on 8-26- 1948

Immediate cause of death
Far advanced bilateral Tuberculosis of Lungs
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration: years

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Hayle Burton M. D.
Address Balto. City Hosp. Date signed 9-3-48

VS 153

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66682

GM. 82666

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G66682

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Von Daniel Veltman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Cornelia (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22- 1862

8. AGE: Years	Months	Days	If less than one day
85	8	27	hr. min.

9. Birthplace Holland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Sidney Veltman
13. Birthplace Holland

MOTHER
14. Maiden Name Bertha Baker
15. Birthplace Holland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 2 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 9 - 1948 (Date received by registrar) Cause for [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 8- 18- 19 48, 2.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7- 16- 19 43 to 8- 18- 19 48 and that I last saw h[illegible] alive on 8- 18- 19 48.

Immediate cause of death Probable bronchopneumonia — both lower lobes — Duration 2 days
Due to Arteriosclerosis of Cardio-vascular disease — 5 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Kirkendall M. D.
Address Balto City Hosp Date signed Sept 48

VS 150

666683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

Registered No. 666683

BM. 121628

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 6-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 20 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 18 N. Bond ST. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** John Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 1 - 1883

8. AGE: Years	Months	Days	If less than one day
65	4	17	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Johnson

13. Birthplace ?

MOTHER

14. Maiden Name Ida ?

15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 2 1948

18 (a) Funeral director Commissioner of Health

(b) Address Baltimore, Md.

19 (a) SEP 9 - 1948 (b) Registrar

(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8- 18 - 1948 at 5.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7- 28 -1948 to 8- 18 -1948, and that I last saw h alive on 8- 18 -1948

Immediate cause of death Cardio-resp failure — Duration mins.

Due to ? CVA. — Duration mins.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/3/48

Major findings of operation: Papilloma of anus

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Jordan Small M. D.

Address Balt City Hosp. Date signed 8/31/48

VS 50

X

Hal 3

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66684

157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State La. (b) County
(c) City or town Shreveport (If outside city or town limits, write RURAL and give town)
(d) Street No. 230 Stoner Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME David Armond Eames

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-16-46

8. AGE: Years 1 | Months 129 | Days 23 | If less than one day hr. min.

9. Birthplace La (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Armond Eames
13. Birthplace Ala.

MOTHER
14. Maiden Name Jessie Mae Gleason
15. Birthplace La

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/45 (month) (day) (year)
(c) Cemetery or crematory Shreveport, La Cemetery
Location

18 (a) Funeral director Chas P Powell
(b) Address 2417 Edmondson Ave

19 (a) SEP 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9-1945, at 5 10a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1945, to 9-9 1945, and that I last saw him alive on 9-9 1945.

Immediate cause of death: Cerebral Anoxia — Duration

Due to Tracheal obstruction

Due to Congenital vocal cord paralysis

Other Conditions Tetralogy of Fallot, Pneumonia

(Include pregnancy within 3 months of death)

Date of operation 9/8/45 Fatal

Major findings of operation: Pulmonic Stenosis

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify which place)
(e) Means of injury

23. Signature Henry F. Sahmer M.D.
Address J Hosp Date signed 9/9/45

G66685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G66685
Registered No.

AB -11906

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 48years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 141 N. Exter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adaline Bottdorf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Benjamine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept- 15-1859

8. AGE: Years	Months	Days	If less than one day
88	11	13	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Dr. John Nevins
13. Birthplace ?

MOTHER
14. Maiden Name Esther Brown
15. Birthplace Pa.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 8 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 9 - 1948 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28- 19 at 12.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3- 1934 to 8-28- 1948, and that I last saw her alive on 8-28-48 1948.

Immediate cause of death Lobar pneumonia — Duration 1 day

Due to

Due to

Other Conditions Hypertension, Heart Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Rechtold M. D.
Address ~~John Rechtold~~ Baltimore City Hosp Date signed 8-3-48

G66686

426999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

✓ G666686 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 18 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Hastings.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Emma Hastings

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 4-4-88

8. AGE: Years 60 | Months 4 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business

FATHER 12. Name Braxton Hastings

13. Birthplace Va.

MOTHER 14. Maiden Name Harriet Simon

15. Birthplace Md.

16 (a) Informant records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 8 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 9 - 1948 (Date rec'd by Registrar) (b) [illegible] M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 27 - 1948. at 11 5-8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26 - 1948. to 8-27 - 1948.
and that I last saw him alive on 8-27 - 1948.

Immediate cause of death: Pneumonia — Duration: 1 week

Due to Bronchiectasis — 1 yr

? Cancer of lung — 2 yrs

Due to Malnutrition
Cachexia

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard S Thomas M. D.

Address JOHNS HOPKINS HOSPITAL Date signed 9/27/48

VS 150

G66687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

32a

G66687

Registered No.

BS-122123

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Balto. City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.

(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 411 Biddle St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jessie Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife John Gross

6 (c) If alive, give age 1922??

7. Birth date of deceased (mo., day, yr.) July 4, 1927

8. AGE: Years	Months	Days	If less than one day
21 or 26 yrs.	11	12	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Scott

13. Birthplace Md.

MOTHER

14. Maiden Name Carrie Jones

15. Birthplace ?

16 (a) Informant Records-Balto. City Hospital

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 8 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 9 - 1948 (b) (Signature of registrar) Washington-Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1948 at 11:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14 1948 to 8-16 1948, and that I last saw her alive on 8-16 1948

Immediate cause of death Probable Infectious Hepatitis — Duration 7 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature L. Stutzman M. D.

Address Balto. City Hosp Date signed 9-8-48

VS 150

G666688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G666688 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3707 Sharmow Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 1
(e) Length of stay in Baltimore (yrs., mos., or days) 54 5.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 Sharmow Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katie Ann Lacey
3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edwin Young Lacey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 31st 1865

8. AGE: 83 Years | Months | Days | If less than one day: hr. min.

9. Birthplace Clinton Ohio (Town, county, and state)

10. Usual Occupation Bore
11. Industry or business

FATHER
12. Name Peter Casen Lisor
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Arni
15. Birthplace Germany

16 (a) Informant Mrs Clinton H DeLutz
(b) Address 3707 Sharmow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11 1948 (month) (day) (year)
(c) Cemetery or crematory Snake Spring Cem
Location Cresaptown Md

18 (a) Funeral director E. Willis Lamonaco
(b) Address 4510 Liberty Heights Ave

19 (a) 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9-1948, at 11.45 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1943, to Sept 1948, and that I last saw h[illegible] alive on 9-9-1948.

Immediate cause of death: Coronary Occlusion — Duration 1 hr
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation No
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harper M. D.
Address 5201 Liberty Oak Date signed 9/9/48

Howard J. Flanagan, M.D.

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

G66689 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estella SPROUSE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 19, 1926

8. AGE: Years	Months	Days	If less than one day
21 2	9	19	hr. min.

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ALONZO SPROUSE
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name ESTER COLEMAN
15. Birthplace VIRGINIA

16 (a) Informant: MR ROY BOARDMAN
(b) Address 1725 HOLLINS ST

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof SEPT 9, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location RICHMOND VIRGINIA

18 (a) Funeral director Henry A. Wyche
(b) Address 4101 Chamberlayne Ave

19 (a) Date received SEP 9 1948 Registrar's signature Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1948, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquest by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxiation by hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sep. 8, 48 at 8 P.M.
(b) Where did injury occur? Jail, Western Dis. Station
(c) Did injury occur at home, on farm, industrial place, in public place? Jail While at work? no
(d) Means of injury hanged self with clip to bars

23. Signature George N. Morrell M.D. Medical Examiner.
Date signed 9-9-48

X

666690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

666690 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4807 Richard Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4807 Richard Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Johnson Chamberlain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Helen L. Wheeler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28-1891

8. AGE: Years	Months	Days	If less than one day
57	-	12	hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Clerk
11. Industry or business Gas & Elec. Co.

FATHER 12. Name Benjamin S. Chamberlain
13. Birthplace Md

MOTHER 14. Maiden Name Mary Howard
15. Birthplace Md

16 (a) Informant Mrs. Helen L. Chamberlain
(b) Address 4807 Richard Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-48 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) 9-9-1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9 1948 at 12:15 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McSadden M.D.
Medical Examiner.
Date signed 9-9-48

VS 181

X

G66691

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52a.

G66691 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1022 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Giunta

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-9488

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband~~ or wife: Mary Giunta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 6th 1879

8. AGE: Years: 69 | Months: 8 | Days: 21 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Piano Finisher

11. Industry or business Retired

FATHER 12. Name Charles Giunta

13. Birthplace Italy

MOTHER 14. Maiden Name Anneta Pistorio

15 Birthplace Italy

16 (a) Informant Chas. T. Giunta

(b) Address 1712 E. 2nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/48 (month) (day) (year)

(c) Cemetery ~~cemetery~~ Holy Redeemer

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1219 St. Paul St.

19 (a) SEP 9 - 1948 (Date received by registrar) Funkhouser (Signature of registrar)

(b) Registered number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7th 1948, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1948, to 3-25 1948, and that I last saw him alive on 3-25 1948.

Immediate cause of death: Hyper nephroma, right Kidney with metastases ~~Due~~ to lungs

Duration: ??

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Singwald M.D.

Address 1109 St Paul St Date signed 9/7/48

VS 150

666692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

666692 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 433 Gwynn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 Gwynn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa V. Purcell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) Dec 24th 1876

8. AGE: Years 71 | Months 8 | Days 14 | If less than one day: hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER 12. Name Patrick Purcell
13. Birthplace Ireland

MOTHER 14. Maiden Name Winifred Joyce
15. Birthplace Ireland

16 (a) Informant Mrs Thomas Cullaran
(b) Address 433 Gwynn Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/11/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) SEP 10 1948 (Date rec'd by registrar) Huntington Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8th 1948, at 8 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to 9/8 1948, and that I last saw h~~er~~ alive on 9/7 1948.

Immediate cause of death: General Visceral Failure — Duration: 9/1/48
Due to: Generalized Arterio Sclerosis — 2 yrs +
Arteriosclerotic Cardiovascular Disease — 2 yrs +
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 3629 Elmora Ave Date signed 9/9/48

X

VS 150

G666693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 464

G666693

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 East Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 East Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Agnes Miner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William J. Miner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 12, 1878

8. AGE: Years 70 | Months 2 | Days 27 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Cornelius Trainor
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Elizabeth Kern
15. Birthplace: Ireland

16. (a) Informant: Mrs. Helen O'Connor
(b) Address: 713 East Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13/48 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Baltimore

18 (a) Funeral director: Rita Fiedefeld
(b) Address: 900 East Biddle St

19 SEP 10 1948 (Date received by Registrar) Huntington Mitchell, M.D. (Registrar) Registrar

VS. 193

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Sept 1948, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1948 to Sept. 9 1948, and that I last saw her alive on 8 Sept. 1948.

Immediate cause of death: Retroperitoneal sarcoma — Duration: 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Louis E. Wice, M.D.
Address 920 St. Paul Date signed 9 Sept. 48

X

G66694 48-19397 G66694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 ST. PAUL ST (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME BABY CHARLES NORTON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-8-48

8. AGE: Years	Months	Days	If less than one day
—	—	—	23 hr. 50 min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation CHILD
11. Industry or business

FATHER
12. Name RICHARD NORTON
13. Birthplace MARYLAND

MOTHER
14. Maiden Name [illegible]
15. Birthplace MARYLAND

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 10 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 9 1948, at 2 35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 1948, to 9-9 1948 and that I last saw him alive on 9-9 1948.

Immediate cause of death: Atelectasis — Duration

Due to

Due to

Other Conditions: Anoxia, Fatal distress, abnormal umbilical cord.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul D Brma M.D.
Address Johns Hopkins Hosp. Date signed 9-9-48

VS 159

666695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 666695

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2509 Linden Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2509 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac L Livingston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mollie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1883

8. AGE: Years 64 | Months 11 | Days 16 | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Jewelery Business

FATHER
12. Name Louis Livingston
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Russia

16 (a) Informant Jules Livingston
(b) Address 2509 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Arlington Cemetery
Location Rogers Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Date received by Local Registrar SEP 10 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8 1948, at 11 - M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Sept 8 1948 and that I last saw him alive on Sept 8 1948.

Immediate cause of death	Duration
Ac. Coronary Thrombosis	
Due to Hypertensive - Arteriosclerotic C.V.H.D	
Due to Generalized Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Willard Applegarth
Address 251[illegible] Reisterstown Rd Date signed 9/9/48 (M) (D)

VS 153

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G666696

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Oakmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Yerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years: 69 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation b: Housewife

11. Industry or business

FATHER
12. Name: Mordecai
13. Birthplace: Russia

MOTHER
14. Maiden Name: Dora
15. Birthplace: Russia

16 (a) Informant: Solomon Yerman
(b) Address: 3607 Oakmont Ave

17 (a) Burial: (Burial, cremation, or removal) (b) Date thereof 9-10-48 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Locatio: Philadelphia Rd & Hamilton Ave

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2100 Eutaw Place

19 SEP 10 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 1948 at 7 20 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/5 1948 to 9/10 1948 and that I last saw her alive on 9/10 1948

Immediate cause of death: Cor Pulmonale — Duration

Due to: Pulmonary Fibrosis

Due to: Bronchiectasis, Chronic

Other Conditions: Old tuberculosis, Diabetes Mellitus.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Epper, M.D.
Address Sinai Hospital Date signed 9/10/48

VS 150

106 K

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

166697 CARTER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. 166697

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Resident

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 W. Mulberry
(Rural route number)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3. (a) FULL NAME Mary Roberta Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Negro

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edward Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/30/[illegible]

8. AGE: Years 39 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm. Bell
13. Birthplace Md.

MOTHER
14. Maiden Name Nanna Harod
15. Birthplace Md.

16. (a) Informant Edward Bell
(b) Address 2124 N. Howard St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-48 (month) (day) (year)

(c) Cemetery or crematory
Location Mt. Calvary

18. (a) Funeral director Halstead & Sullivan
(b) Address 915 [illegible]

19. SEP 10 1948 (Date received by Registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5 1948 at 1205 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3 1948 to 9-5 1948 and that I last saw her alive on 9-2 1948

Immediate cause of death: Acute Dilatation of Heart — Duration

Due to Cardiac Enlargement

Due to

Other Conditions Marginal Pulmonary Edema
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature E. Brodsky M.D.
Address 1514 Division St Date signed 9-7-48

VS 150

666698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

926

Registered No. 666698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 245 N. Pearl St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM HAZELTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Isabattie Hazelton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 14, 1908.

8. AGE: Years 40 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Md.. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Hazelton.
13. Birthplace Md...

MOTHER
14. Maiden Name Mollie
15. Birthplace Md..

16 (a) Informant Catherine Reaves.
(b) Address 245 N. Pearl St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13 1948 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Mrs Katie R. Wilbright
(b) Address 322 N. Schroeder St

19 SEP 10 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1948, at 5.15PM

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute dilatation of heart

Due to Chronic valvulitis - mitral & aortic

Due to Chronic vegetation, mitral.

Other Conditions Adrenal tumor

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D. Medical Examiner.
Date signed September 8, 1948

VS 191

X

G66699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66699

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4220 Loch Raven Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4220 Loch Raven Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY CATHERINE SEMMLER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles A. Semmler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1858

8. AGE: Years 90 | Months 7 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Sulthaus
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Kaiser
15. Birthplace Germany

16 (a) Informant Mr. Frederick Siebert
(b) Address 4220 Loch Raven Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 7 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 8, 1948, at 9.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1948, to 8 Sept. 1948, and that I last saw h.e alive on 8 Sept. 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Arteriosclerotic Cardio Vascular Disease	
Due to With Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address Date signed

VS 150

Information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

866700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(93)

Registered No. 866700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 S. Conklin Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 S. Conklin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CORA ELLEN DAVIS

3 (b) If veteran, name war: No

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles W. Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 3, 1874

8. AGE: Years 74 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Saunders
13. Birthplace Virginia

MOTHER
14. Maiden Name Robinette Broach
15. Birthplace Virginia

16 (a) Informant Mrs. Emma Richardson
(b) Address 711 S. Conklin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 10 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 5 1943, to Sept 8 1948, and that I last saw h.. alive on Sept 7 1948.

Immediate cause of death: Uremia - Sept 8
Prostatectomy Feb 24 1944 Sept 4
Due to Myocarditis 1943
Hypertension 1942
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 1948 / 1944 / 1943 / 1942

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abram L. DeLaura M. D.
Address 3426 Bull St. Date signed 9/9/48

VS 190

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

666701 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1225 N. Washington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Boddie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 23, 1910

8. AGE: Years	Months	Days	If less than one day
37 38	9	16	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Unemployed Laborer
11. Industry or business

FATHER
12. Name William Boddie
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Boddie
15. Birthplace N. C.

16 (a) Informant William Boddie
(b) Address 1816 E Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10/48 (month) (day) (year)

(c) Cemetery or crematory
Location Rocky Mt N. Carolina

18 (a) Funeral director Robert G. Elliott Dept
(b) Address 1098 N. Carrie St

SEP 10 1948 (Date received by registrar)

(b) Signature and title of registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9/48 19 , at 7:50 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma Rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(c) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 9/9/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

666702

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 S. Caroline Dept St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 S. Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Waugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Arthur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1901

8. AGE: Years 47 | Months 6 | Days " | If less than one day hr. min.

9. Birthplace Oxford N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Mark Parham
13. Birthplace N. C.

MOTHER 14. Maiden Name Isabelle Parham
15. Birthplace N. C.

16 (a) Informant Mazzie Clark
(b) Address 114 S Caroline St

17 (a) Burial (b) Date thereof 9/10/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A G County Md.

18 (a) Funeral director Mrs Pott & Ellis Dept
(b) Address 112 N. Caroline St

19 (a) Date received by (Registrar) SEP 10 1948
(b) Registrar Washington Whitehurst M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1948 at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic pyelonephritis
Abdominal urinary fistula

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. G. Solomon M.D.
Medical Examiner.
Date signed 9/7/48

VS 151

G66703

Weinberger

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G66703 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3313 Moravia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3313 Moravia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Valentine H. Steininger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Annie - nee Lebrad

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 18-1876

8. AGE: Years	Months	Days	If less than one day
71 70	9	20	hr. min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name	John Steininger
13. Birthplace	Germany
MOTHER 14. Maiden Name	Barbara Lipple
15. Birthplace	Germany

16 (a) Informant Mrs. Annie Steininger

(b) Address 3313 Moravia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 13 48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Rd

19 (a) SEP 10 1948 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1948 at 10:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9- 1946 to 9-8- 1948 and that I last saw him alive on 9-8- 1948.

Immediate cause of death: myocardosis — Duration

Due to: Arteriosclerotic cardiovascular disease

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature John J. Gould M. D.

Address 1418 Eastern Date signed 9-10-48

66704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 66704

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2401 Hamilton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Hamilton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evan O. Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widowed

6 (b) Name of husband or wife Frances T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-15-1870

8. AGE: Years	Months	Days	If less than one day: hr.	min.
77	9	29		

9. Birthplace N J
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Evan O. Edwards
13. Birthplace Wales

MOTHER
14. Maiden Name Ada Young
15. Birthplace N J

16 (a) Informant Frances T. Edwards
(b) Address 2401 Hamilton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Leonard J. Klingle
(b) Address 4205 Wentworth Rd.

19 (a) SEP 10 1948 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1948 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1948 to Sept 8 1948, and that I last saw him alive on Sept 6 1948.

Immediate cause of death Myocardial insufficiency

Due to

Due to

Other Conditions Arteriosclerosis, hypertension, myocarditis
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature John A. Schwenck
Address 1837 S. Charles St. Date signed 9/8/48

Examined

666705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666705

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun.
(c) Hospital or institution:
Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. None Rec
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida LEITH

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband unknown

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 29 Apr 83

8. AGE: Years 65 | Months 4 | Days 11 | If less than one day hr. 10 min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation Retired Housewife

11. Industry or business

MOTHER / FATHER

12. Name Mason Walker

13. Birthplace W. Va.

14. Maiden Name Mildred A Hergerman

15. Birthplace W. Va.

16 (a) Informant Mrs. W. J. Walker

(b) Address 1305 Poplar Grove St

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof 9/12/48 (month) (day) (year)

(c) Cemetery or crematory White

Location Balto. Md.

18 (a) Funeral director Charles P. Powell

(b) Address 2417 Edmondson Ave

19 SEP 10 1948 (Date rec'd by registrar)

(b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Sep 1948, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 Sep 1948 to 9 Sep 1948, and that I last saw her alive on 9 Sep 1948.

Immediate cause of death Pulmonary Embolism — Duration 2-3 hrs.

Due to Phlebo Thrombosis R. Leg. — Duration 4 wks.

Due to

Other Conditions Asthma. allergic
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: —

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work

(e) Means of injury

23. Signature Roman V. [illegible] M. D.

Address Franklin Sq. Hosp Date signed 9-10-48

PHYSICIAN

Underline the cause to which death should be charged statistically

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 666706

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 56 years

2. USUAL RESIDENCE OF DECEASED:

(a) Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and name of town)

(d) Street No. 407 Elvino St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Helen Catherine Zellers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Married

6 (b) Name of husband or wife: Adam Edward Zellers

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 2/3/1892

8. AGE: Years 56 | Months 7 | Days 6 | If less than one day: ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation House-Work.

11. Industry or business At Home

FATHER — 12. Name Joseph Zuchowski

13. Birthplace Poland.

MOTHER — 14. Maiden Name Mary ?

15. Birthplace Poland

16 (a) Informant Adam E. Zellers

(b) Address 407 S. Elvino St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-48 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Cem. Location German Hill Rd.

18 (a) Funeral director Charles S. Giles

Address 991 S. Conkling St.

SEP 10 1948

19 (a) ____ (Date rec'd by registrar) (b) Registrar Washington

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1948 at 4:35 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 22 1948 to Sept 9 1948 and that I last saw him alive on Sept 9 1948

Immediate cause of death	Duration
Myocardial Failure	
Due to Generalized Toxemia	
Due to Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at ____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify which)

(e) Means of injury

23. Signature Ray C. Pusono Jr.

Address St. Joseph's Hosp. Date signed 9/9/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 666707

~~675707~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 Rosedale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 9
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr. 3 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 1408 Rosedale St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Rose A. McGonigal

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife James Thomas McGonigal (If alive, give age — years)

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1871

8. AGE: Years 76 | Months 11 | Days 10 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Ridgely
13. Birthplace Marylobrdt

MOTHER
14. Maiden Name Amelia ?
15. Birthplace Maryland

16 (a) Informant Thomas M. McGonigal
(b) Address 1408 Rosedale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11/48 (month) (day) (year)
(c) Cemetery or crematory Harmony Cem. Location Howard Co. Md.

18 (a) Funeral director Eastern Stone
(b) Address Ellicott City Md.

SEP 10 1948 (Date rec'd by registrar)

(b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1948 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to 9-9 1948, and that I last saw h[illegible] alive on 9-9 1948.

Immediate cause of death	Duration
Acute Pulmonary Edema	1 day
Due to Hypertension C-V-D	1 year
Due to Cerebral Hemorrhage - Hemiplegia	15 min.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically

23. Signature Leo Galiman M. D.
Address [illegible] Date signed 9-7-48

VS 180

X

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

666708 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 Edmondson
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 803 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie B. West
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Wm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/23/73

8. AGE: Years 75 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation domestic
11. Industry or business

FATHER
12. Name Joseph Nichols
13. Birthplace md

MOTHER
14. Maiden Name Annie M. Cassell
15. Birthplace md

16 (a) Informant Mrs. Emma West
(b) Address 803 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pressman St

19 Filed Sept 13 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1948 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1948 to Sept 8 1948 and that I last saw h alive on Sept 8 1948

Immediate cause of death
Ch. Myocarditis — Duration 7 yrs
Due to Pulmonary Embolus — 2 dys
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Woodland M. D.
Address 801 Edmondson Ave Date signed Sept 8 1948
CHARLES WOODLAND

PHYSICIAN
Underline the cause to which death should be charged statistically.

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 21

G66709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66709 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 Whatcoat St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give name)
(d) Street No. 1216 Whatcoat St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Wm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/31/1909

8. AGE: Years	Months	Days	If less than one day
39	7	9	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Wm Taylor
13. Birthplace Va

MOTHER
14. Maiden Name Henrietta Jones
15. Birthplace Va

16 (a) Informant Wm Jones
(b) Address 1216 Whatcoat St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/48 (month) (day) (year)
(c) Cemetery or crematory Northumberland
Location Northumberland Co. Va

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) Filed by registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9 1948 (Year) 6A M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/3 1948 to 9/9 1948, and that I last saw him alive on 9/8 1948.

Immediate cause of death — Duration

Due to Pulmonary Tuberculosis

Due to Tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. M. Rhetta
Address 2139 Druid Hill Ave Date signed 9/9/48

B. M. RHETTA X

VS 190

Type or write with PERMANENT BLACK INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G66710

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

G66710 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (3)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Bloom St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John LITTLE

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-6669

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Ennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/5/1893

8. AGE: Years 54 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Usa (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Little
13. Birthplace Usa

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Ennie Little
(b) Address 533 Bloom St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Edw. H. Nelson
(b) Address 1303 Druid Hill Ave

19 (a) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1948, at 8:05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilation of heart.
Edema of lungs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 9/8/48

VS 151

Mal 4
G66711

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30

✓ G6671T
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N Dallas St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Missie Foreman ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo. day, yr) 3-11-81

8. AGE: Years	Months	Days	If less than one day
67	5	29	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Spell
13. Birthplace N.C.

MOTHER
14. Maiden Name Fabbie ?
15. Birthplace N C

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/48 (month) (day) (year)
(c) Cemetery or crematory Greenville, N.C.
Location Greenville N.C.

18 (a) Funeral director Leo. H. Nelson
(b) Address 130 3 Priestman St

SEP 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9 1948, at 6 30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1948 to 9-9 1948 and that I last saw her alive on 9-9 1948.

Immediate cause of death
Internal Hemorrhage, Thoracic
Due to Aneurysm of Aorta
Due to Syphilis
Other Conditions
(Include pregnancy within 3 months of death)

Duration
2 days
7 years
Many years.

Date of operation August 31, 1948
Major findings of operation: Attempt to wire aneurysm
of autopsy: Aortic Aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature David C. Sorsby Jr. M.D.
Address Johns Hopkins Hosp. Date signed 9/9/48

X

G66712 OC-48-1538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Bolyard 159

Registered No. G66712

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address So. Balt. Gen. Hosp.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs. 10 min.

(e) Length of stay in Baltimore (yrs., mos., or days) 5 hrs. 10 min.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town (If outside city or town limits, write RURAL and give town) 25

(d) Street No. 4236 6th St. B. G. Hosp. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Daughter of Roy & Mamie Bolyard.

3 (b) If veteran, name war —

6 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/9/48

8. AGE: Years | Months | Days | If less than one day 5 hr. 10 min.

9. Birthplace S. B. G. Hosp. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER

12. Name Roy Bolyard

13. Birthplace W. Virginia

MOTHER

14. Maiden Name Mamie Bolyard

15. Birthplace W. Virginia

16 (a) Informant Mamie Bolyard

(b) Address W. Virginia

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 10 48 (month) (day) (year)

(c) Cemetery or crematory CEDAR HILL

Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, Inc

(b) Address 715 LIGHT ST - 30

19 (a) (Date received by registrar) (b) Signature of registrar

SEP 10 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9/48 19 at 8:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3:15 P.M. 9/9/48 to 8:25 P.M. 9/9/48 and that I last saw h e alive on 9/9 19 48.

Immediate cause of death Atelectasis

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 5 hrs. 10 min.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] Phys. M.D.

Address 1866 Date signed 9/9/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G66713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 PATAPSCO AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 PATAPSCO AVE BALTIMORE, MD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT PEDDLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife FRANCES NOSEWORTHY
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) FEB 25, 1877

8. AGE: Years	Months	Days	If less than one day
71	6	13	hr. min.

9. Birthplace NEWFOUNDLAND (Town, county, and state)
10. Usual Occupation
11. Industry or business RETIRED

FATHER
12. Name SAMUEL PEDDLE
13. Birthplace NEWFOUNDLAND

MOTHER
14. Maiden Name SELINA PEDDLE
15. Birthplace NEWFOUNDLAND

16 (a) Informant MRS FRANCES PEDDLE
(b) Address 411 PATAPSCO AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 11 48 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST - 30

SEP 10 1948 (a) (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8/1948, at 9:? M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1948 to Sept 8 1948 and that I last saw h[illegible] alive on Sept 8 1948.

Immediate cause of death	Duration
Coronary occlusion	
Due to	
Due to Hypertension	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Peddle M. D.
Address 203 Valley Date signed

G66714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G66714 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Harford Rd. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME. Michael J Casey

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-8606

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 11/4/1880

8. AGE: Years	Months	Days	If less than one day
68	10	4	hr. min.

9. Birthplace Ireland (town, county and state)

10. Usual Occupation Retired Watchman

11. Industry or business Locke Insulator Corp.

FATHER
12. Name Thomas Casey
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary D Sagman
15. Birthplace Ireland

16 (a) Informant Mrs. Edna B. Knepper (Niece)
(b) Address 2921 Hillcrest Ave, Balto 14, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mon, Sept 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Near Cathedral
Location Balto Md

18 (a) Funeral director C. J. Howard & Sons
(b) Address 1405 Charles St Balto 3 Md

19 (a) SEP 10 1948 (Registrar) (b) Registrar Hamilton for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Wed 9/8/48 1948, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1948, to Sept 8 1948, and that I last saw h/ alive on Sept 8 1948.

Immediate cause of death	Duration
Acute peritonitis	
Rupture of sigmoid	
Due to Intestinal obstruction	
Due to Ca of sigmoid colon	
Other Conditions Ventral hernia, Diaphragm Hernia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Exp

of autopsy: Acute peritonitis, Ca sigmoid

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph L. Arcuti
Address Mercy Hosp Date signed 9/9/48

G66715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 937

G66715
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 2075 Rockrose Ave.
(c) Hospital or institution: Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1934 E. 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID THOMAS WORK

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Mary Alice Work

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 10, 1860

8. AGE: Years: 88 Months: 4 Days: 28 If less than one day: hr. min.

9. Birthplace: Cecil Co., Md. (Town, county, and state)

10. Usual Occupation: Retired Signalman

11. Industry or business: B. & O. R. R. Co.

FATHER
12. Name: David Work
13. Birthplace: Cecil Co., Md.

MOTHER
14. Maiden Name: Sarah Butler
15. Birthplace: Cecil Co., Md.

16 (a) Informant: Mr. Joseph W. Work
(b) Address: 639 Plymouth Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/48 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8, 1948 at M

21. I certify that death occurred on the date above stated, at [illegible] and that I last saw [illegible] alive on Sept 7 1948

Immediate cause of death: Chronic hypertension + Arteriosclerosis — Duration: yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Henry C Houck
Address: 1934 Wyndhurst Ave Date signed: Sept 9/48

VS 150

Cause of death age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The

666716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

87E

Registered No. 666716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital. 1 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED
(a) State maryland (b) County Baltimore
(c) City or town Baltimore 10, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 West 39th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David June Carver Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of ~~husband or~~ wife Catherine Carver.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 24 1916

8. AGE: Years 32 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, maryland. (Town, county, and state)

10. Usual Occupation Apprentice Broker

11. Industry or business

FATHER 12. Name David J. Carver Sr.
13. Birthplace Tennessee

MOTHER 14. Maiden Name Hallie Council
15. Birthplace Virginia

16 (a) Informant Mr. David J. Carver
(b) Address 217 Chancery Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Fairfax Courthouse Cem.
Location Fairfax, Va.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1918 Eutaw Pl.

19 (a) SEP 10 1948 (Date rec'd by registrar) Huntington Williamson M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1948 at 5:29 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1948 to Sept 9 1948, and that I last saw him alive on Sept 9 1945.

Immediate cause of death Intracranial hem, left parietal lobe, — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/5/48

Major findings of operation Hemorrhage, left parietal lobe,

of autopsy Intracranial hemorrhage left parietal lobe.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn P. Grow M.D.
Address Union Memorial Hospital Date signed 9/9/48

VS 150

X

G66717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66717

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use typewriter, with UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3007 Clearview ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3007 Clearview ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Brougher

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Harry F. Brougher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21. 1884

8. AGE: Years	Months	Days	If less than one day
63	8	19	hr. min.

9. Birthplace Harrisburg, Pa
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Godfrey Boke
13. Birthplace Pa

MOTHER
14. Maiden Name Alice Cripple
15. Birthplace Pa

16 (a) Informant Mr. Harry F. Brougher
(b) Address 3007 Clearview ave

17 (a) Burial (b) Date thereof 9/13/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave

18 (a) Funeral director Edgar N. Pilpel Jr.
(b) Address 6009 Harford Road

19 (a) SEP 10 1948 Registered in Baltimore, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1948 at 7:57 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1948. to Sept. 9, 1948 and that I last saw h alive on Sept. 9, 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 48 hr.

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan Janney M.D.
Address 7101 Harford Rd Date signed 9/10/48

VS 150

G66718

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66718
Registered No. 163

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 Aiken St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2300 Aiken St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER V. SMITH, JR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 19, 1924

8. AGE: Years	Months	Days	If less than one day: hr.	min.
24	0	21		

9. Birthplace Washington D C (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Walter V. Smith Sr
13. Birthplace Balto Md

MOTHER
14. Maiden Name Agnes M Sylvester
15. Birthplace Frederick Md

16 (a) Informant Walter V. Smith Sr.
(b) Address 2300 Aiken Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-48

(c) Cemetery or crematory Lakewood
Location Balto Md

18 (a) Funeral director Leonard Hecht
(b) Address 1 [illegible] Hartford Road

SEP 10 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1948, at 9:05AM

21. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation
CARBON DIOXIDE
Due to Barbiturate Poisoning
Effects
Other Conditions Mental depression
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/6/48 at P. M.
(b) Where did injury occur? 2300 Aiken St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Ingestion of sleepin tablets

23. Signature Homer J. Madeira M.D.
Medical Examiner.
Date signed 9/10/48

VS 151

066719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 066719

AR-121653

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) 76years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3605 Belvedere Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ryan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo. day. yr Oct. 23-1871

8. AGE: Years 76 | Months 10 | Days 16 | If less than one day hr min

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name William Ryan
13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Howard
15. Birthplace Scotland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) 9/11/48 burial (Burial, cremation, or removal) Date thereof 9/11/48 (month) (day) (year)
(c) Cemetery or crematory St. Peter's
Location Balto. City.

18 (a) Funeral director C. Vernon Emerson
(b) Address 4611 Park Heights Ave.

19 (a) Reg. No. (b) Registrar Huntington Williams, M.D.
(Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9- 1948 at 7.30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 7-29 1948, to 8-9- 1948, and that I last saw her alive on 9-9- 1948

Immediate cause of death Pulmonary Embolism Cerebral Vascular accident — Duration

Due to

Due to

Other Conditions Fracture neck of femur subcutaneous
(Describe pregnancy if within 3 months of death)

Date of operation 8/2/48

Major findings of operation: Fracture neck of femur

of autopsy: none

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 2-28-48
(a) Accident, ~~suicide or homicide~~
(b) Date of occurrence 7-28-48 at 4 P. M
(c) Where did injury occur? Baltimore St. near Beaconsfield (Specify type of place)
(d) Did injury occur about home, on farm, industrial place) in street While at work? (Specify type of place)
(e) Means of injury fell to ground

23. Signature H. J. Madden M.D.
Address Baltimore City Hospitals Date signed 9/9/48

VS 150 TO BE APPROVED BY THE MEDICAL EXAMINER for B.J.S. ordered by H. J. Madden M.D.

666720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. 666720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 E. Fernhill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MR WILLIAM A. MURRAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-22-1870

8. AGE: Years	Months	Days	If less than one day: hr.	min.
78	5	17		

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name James A. Murray
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Susan Bien
15 Birthplace Penna.

16 (a) Informant Mary Catherine Murray
(b) Address 418 E. Fernhill Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/11/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. City.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) [illegible] (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8-1948, at 1:35 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9-6 1948 to 9-8 1948 and that I last saw him alive on 9-8 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary occlusion acute	
Due to Coronary atherosclerosis and hypertensive myocardial	years
Other Conditions Mitral insufficiency. Pleural adh.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None Tentative

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) State
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Siva M.D.

Address Mercy Hosp Date signed 9-8-48

VS-150

66721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. 66721

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 E 23rd St
(c) Hospital or institution: Beck's Diagnostic Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 E. 20th. St.
(If rural give location)
(e) Citizen of foreign country? —— (Yes or No)
If yes, name country

3 (a) FULL NAME James K. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1895

8. AGE: Years 52 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Valuator,

11. Industry or business Home Owners Loan Corp.

FATHER
12. Name James B. Smith,
13. Birthplace Va.

MOTHER
14. Maiden Name Ella Jane Kelly,
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Helen Smith,
(b) Address 521 E. 20 th. St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral,
Location Balto. City.

18 (a) Funeral director C. Vernon Lawrence,
(b) Address 4611 Park Heights Ave.

19 (a) [illegible] (b) Huntington Williams, M.D.
(Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1948, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1948, to Sept 9 1948, and that I last saw h alive on Sept 9 1945.

Immediate cause of death — Tuberculosis of lungs Acute — Duration Indefinite

Due to Malnutrition & Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathaniel M. Beck M. D.
Address 100 E. 23rd St Date signed Sept 9, 48

VS 150

Clemmon

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66722

B-121948

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

8-2 R

Registered No. 666722

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Cutamony

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 50? Months Days If less than one day hr. min.

9. Birthplace Md? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospital
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 2 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 10 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17 1948 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8- 1948 to 8-17 1948 and that I last saw him alive on 8-17 1948

Immediate cause of death CEREBRAL THROMBOSIS — Duration 9 DAYS

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas P. Gerrigan M. D.
Address Baltimore City Hosp Date signed 8-25-48

VS 150

G66723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. G66723

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2Mo. 13Da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Glen Burnie (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Central Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lossing, Alfred. Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1940

8. AGE: Years 8 | Months 3 | Days 1 | If less than one day hr. min.

9. Birthplace Lynchburg, Va. (Town, county, and state)
10. Usual Occupation Student
11. Industry or business Glen Burnie Elementary

FATHER
12. Name Alfred W. Lossing Sr.
13. Birthplace Detroit, Mich.

MOTHER
14. Maiden Name Ann M. Clarke
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Alfred W. Lossing Sr.
(b) Address 400 Central Ave., Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11, 48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas V. Singleton
(b) Address Glen Burnie, Md.

SEP 10 1948 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8, 1948, at 5:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25, 1948 to Sept. 8, 1948, and that I last saw him alive on Sept. 8, 1948.

	Duration
Immediate cause of death: Subarachnoid Hemorrhage	
Due to: Acute lymphatic leukemia	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Inman
Address Sinai Hospital Date signed 9/8/48

VS 150

Important: Physicians: please write the causes of death clearly and legibly.

666724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

666724 Registered No.

Please answer all questions. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3218 abell Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3218 abell Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida M. Sheter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Widow

6 (b) Name of husband or wife Alapius J Sheter
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 12/21/1872

8. AGE: Years	Months	Days	If less than one day hr.	min.
75	8	19		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Smith
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Brown
15. Birthplace Baltimore Md

16 (a) Informant Miss R Sheter
(b) Address 3218 abell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory Carlton
Location Old Frederick Rd

18 (a) Funeral director J J Tobey & Sons
(b) Address 1818 Eighteen

19 SEP 11 1948 (Date rec'd by registrar) (By) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1948 at 7 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to 9-10 1948.
and that I last saw her alive on 9-10 1948.

Immediate cause of death Adenocarcinoma of Colon — Duration 1

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilmer N. Fuesting M. D.
Address 11 E. Chase St. Date signed 9-10-48

VS 150

666725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

ES- 927

666725 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 854 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Poland

3 (a) FULL NAME Anna Banks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1869

8. AGE: Years 79 | Months | Days | If less than one day: hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant RECORDS-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Edmondson Ave & Fulton Ave

18 (a) Funeral director P. J. Fahey Funeral Home
(b) Address 1731 Light St., Huntington Williams, Inc.

19 (a) SEP 11 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26- 1948 at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8- 1933 to 8-26 1948, and that I last saw her alive on 8-26- 1948

Immediate cause of death	Duration
Bronchopneumonia, bilat	3 Days.
Due to Cerebral Vascular Accident	2 yrs.
Due to Hypertensive Arteriosclerotic Heart Disease	5-10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Richards M. D.
Address Balto City Hosp Date signed 9-10-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

V- 666726 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Allendale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley Wisman - Stanley C. Weisman

3 (b) If veteran, name war

3 (c) Social Security Account No. 213 05 6498

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Isabelle Bass

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1905

8. AGE: Years 43 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Carefull Laundry

11. Industry or business

FATHER 12. Name Chas. Weisman

13. Birthplace Md

MOTHER 14. Maiden Name Minnie Berger

15. Birthplace Md

16 (a) Informant Isabelle Weisman

(b) Address 713 Allendale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11/48 (month) (day) (year)

(c) Cemetery or crematory Maryland Memorial

Location Taylor Ave. Balto. Md

18 (a) Funeral director Henry H. Kittle

(b) Address 1 Edmondson

19 Sep 1 1948 (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8 1948, at 5 10 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert B. McFadden M.D. Medical Examiner.

Date signed 8-9-48

VS 151

666727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 666727

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2612 Lehman St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2612 Lehman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country NO

3. (a) FULL NAME Evalyn S. Miles

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NO

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ira B. Miles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 11, 1883

8. AGE: Years 65 | Months 2 | Days 29 | If less than one day: hr. min.

9. Birthplace: Wilmington, Del.
(Town, county, and state)

10. Usual Occupation: Home

11. Industry or business: Home

FATHER
12. Name: John Bennett
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary Swacker
15. Birthplace: Wilmington, Del

16 (a) Informant: Clyde H. Miles
(b) Address: 3024 Raynor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 13, 48 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn, Md.

18 (a) Funeral director: John T. Stansbury
(b) Address: 2700 Edmondson Ave.

19 SEP 11 1948 (a) Date rec'd by Registrar (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1948 5:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1948 to 9/10 1948 and that I last saw her alive on 9/9 1948

Immediate cause of death: Uremia — Duration: 10 days

Due to: Chronic Nephritis — 15 Months

Due to: General Arteriosclerosis — 15 Years

Other Conditions: Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Elias W. Solomon M.D.
Address 3432 Fredericks Ave. Date signed 9/12/48

VS 150

131a

G66728

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66728 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2246 E. Lehaire St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore yrs., mos., or days Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No 2246 E Lehaire St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis L Baker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Annie L
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 17th 1878

8. AGE: Years	Months	Days	If less than one day
70	6	22	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Section
11. Industry or business

FATHER
12. Name Wm B. Baker
13. Birthplace Md

MOTHER
14. Maiden Name Annie Hull
15. Birthplace Md

16 (a) Informant Mrs Annie Baker
(b) Address 2246 E. Lehaire St.

17 (a) Burial (Burial, cremation, removal) (b) Date thereof Sept 15th 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo S. Cook
(b) Address 1701-03 N. Patterson Park ave

19 SEP 11 1948 (Date rec'd by Registrar) Huntington 11 Md (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9th 1948, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Sept 9 1948 and that I last saw him alive on Sept 9 1948

Immediate cause of death: Cerebro-Vascular Accident — Duration 17

Due to: Hypertension

Due to: Uremia

Other Conditions (including pregnancy): Acute Cardiac Dilatation

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about: home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred Buzby M. D.
Address 104 N Fulton Ave Date signed Sept 10 48

666729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666729

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 N. Lakewood Ave
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 N Lakewood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette B. Appel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edw. Appel 1878

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) June 2, 1878

8. AGE: Years 70 Months 3 Days 8 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Philip Mickunon

13. Birthplace Balto

MOTHER 14. Maiden Name Mary Kessler

15. Birthplace Balto

16 (a) Informant Edw. Appel

(b) Address 813 N Lakewood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem City

Location

18 (a) Funeral director Ulrich Funeral Home

(b) Address 1908 Pleasant St Huntington for Wilmington, Del

SEP 11 1948

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1948, at 11:30 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1948 to Sept 10 1948, and that I last saw h[im] alive on Sept 10 1948.

Immediate cause of death: Myocardial Infarction — Duration

Due to: Coronary Sclerosis and

Due to: Terminal coronary occlusion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept 5, 1948

Major findings of operation: Chronic Cholecystitis

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vernon H. Norwood M. D.

Address Church Home & Hospital Date signed 9-13-48

VS 130

Please age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. 128

G66730
AB-122797

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G66730
Registered No. 82a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Brentwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Clarence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 7-1902

8. AGE: Years	Months	Days	If less than one day
46	5		hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Gilford Draughn
13. Birthplace ? Halifax Co. N.C.
MOTHER
14. Maiden Name Charlotte Draughn
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 12, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Thos. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Date received by registrar SEP 11 1948 (b) Registrar's signature for Wm. [illegible], Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8- 1948, at 10.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8- 1948, to 9-8- 1948 and that I last saw her alive on 9-8- 1948.

Immediate cause of death Cerebro-vascular accident
Due to Chronic hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 2 hrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. F. Nelson
Address Balt City Hosp Date signed 9/9/48

VS 150 TO BE APPROVED BY THE MEDICAL EXAMINER

666731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

Registered No. 666731

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 247 N Schroeder St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 247 N Schroeder St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel J Gross
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 8 1862
8. AGE: Years 85 Months 11 Days 1 If less than one day hr. min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel J Gross
13. Birthplace Md

MOTHER
14. Maiden Name Bergmann Moore
15. Birthplace Balto Md

16 (a) Informant Edith Gross
(b) Address 247 N Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12 48 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem
Location Baltimore County

18 (a) Funeral director Donald L Bramson
(b) Address 1856 Montgomery St

19 (a) SEP 11 1948 (Date rec'd by registrar) (b) Filed by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1948 at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1948 to Sept 9 1948, and that I last saw he alive on Sept 8 1948.

Immediate cause of death Uremia. — Duration Unknown

Due to Chr. Glomerular Nephritis — Duration Unknown

Due to — Duration

Other Conditions: Congestive Heart failure — Duration Unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Harland Thrift Jr M. D.
Address 902 W Franklin St Date signed 9-10-48

VS 150

Form 1 for Maryland

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66732

48- 122726

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66732

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 802 China St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Mills

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Separated

6 (b) Name of husband or wife Annie Cooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept- 5- 1905

8. AGE: Years	Months	Days	If less than one day
43	-	3	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Sheppard Mills (D
13. Birthplace N.C.

MOTHER
14. Maiden Name Lizzie Watkins (D
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13 48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Balto Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1018 W Montgomery St

19 (a) SEP 11 1948 (Date rec'd by registrar) (b) Huntington W Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8- 1948, at 3 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-5- 1948 to 9-8- 1948 and that I last saw him alive on 9-8- 1948

Immediate cause of death BILATERAL PULMONARY TUBERCULOSIS — Duration 3 mo??

Due to

Due to

Other Conditions PNEUMONIA
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: NONE

of autopsy: SAME AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

18. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence , at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas P. Jennings M. D.
Address BALTIMORE CITY HOSP Date signed 9-9-48

VS 150

66733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1927

Registered No. 666733

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 643 S. Pulaski Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 643 S. Pulaski Street (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES WILLIAM BYERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ELLA R. BYERS
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr) OCT. 3 / 1877

8. AGE: Years 70 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace BRIDGETON . . . IND.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name JESSIE BYERS
13. Birthplace IND.

MOTHER
14. Maiden Name KATHERINE WEBSTER
15. Birthplace IND.

16 (a) Informant MRS. ELLA R. BYERS (WIFE)
(b) Address 643 S. PULASKI STREET

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 11-48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE . . . 17

19 (a) SEP 1 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 8 th. 1948 at 9:15 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 26 MAY 48 to 8 SEP 1948.
and that I last saw him alive on 8 SEP 1948.

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 9 DAYS
Due to ARTERIOSCLEROSIS — 1 YR
Due to CARDIO-VASCULAR DISEASE
Due to ARTERIOSCLEROSIS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following: NO
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (If not at work)
(Specify type of place)
Means of injury

23. Signature Edward J. Mc Cann M.D.
Address 682 WASHINGTON BLVD. Signed 9 SEP 48
BALTIMORE - 30 MD

Correct Age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 159

666734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. 666734

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3rd floor 300 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christine PARKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife: Separated

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2 - 1912

8. AGE: Years	Months	Days	If less than one day
35 36	11	5	hr. min.

9. Birthplace NC (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Willie Springfield
13. Birthplace NC

MOTHER
14. Maiden Name Lucinda Worth
15. Birthplace NC.

16 (a) Informant Lucinda Lunsford
(b) Address 300 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-48 (Month) (Day) (Year)
(c) Cemetery or crematory Arlington
Location Memorial Park

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) SEP 11 1948 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1948, at 8:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Stab-wound of lung.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 7, 48 approx. P. M.
(b) Where did injury occur? Rear of house above address
(c) Did injury occur at home, on farm, industrial place, in public place? Home White at work? No
(d) Means of injury Sharp instrument

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 9/8/48

X

666735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121B

Registered No. 666735

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4807 Norwood Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nelson Deduit Ningard

3 (b) If veteran, name war: World War #2
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Eurith M. Ningard nee Blamberg
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr): 2-18-09
8. AGE: Years 39 | Months 6 | Days 21 | If less than one day: hr. min.
9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual Occupation: Salesman
11. Industry or business: McDowell Pyle & Co.

FATHER
12. Name: Oliver Ningard
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Mary L. Wilson
15. Birthplace: Baltimore

16 (a) Informant: Mrs. Eurith M. Ningard
(b) Address: 4807 Norwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1948, at 11:58 AM

21. I certify that death occurred on the date above stated; that I attended deceased from [redacted] 1948 to 9-10 1948, and that I last saw him alive on 9-10 1948.

Immediate cause of death: Cardio-respiratory renal failure — Duration: 2-3 mos

Due to: Chronic glomerulonephritis — 7 years

Due to:

Other Conditions: uremia, pulmonary edema hypostatic (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret Louise Cadle M. D.
Address Maryland Gen'l Hosp. Date signed 9/10

X

666736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

956

Registered No. 666736

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 S. East Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME MARY ARLENE MUELLER

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Fred F. Mueller
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 14, 1913
8. AGE: Years 34 | Months 9 | Days 26 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas M. Smith
13. Birthplace Baltimore

MOTHER
14. Maiden Name Florence Frey
15. Birthplace Glen Rock, Pa.

16 (a) Informant Mr. Fred F. Mueller
(b) Address 410 S. East Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.
18 (d) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) SEP 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1948, at 2:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3 1948, to 9/10 1948, and that I last saw her alive on 9/10 1948.

Immediate cause of death Rheumatic heart disease — Duration

Due to: Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Judith B. Landau M. D.
Address Sinai Hospital Date signed 9/10

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666737

666737 B 248-18279 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: Franklin Square Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1047 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIUS JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-27-48

8. AGE: Years	Months	Days	If less than one day
		14	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Johnson
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Irene Carter
15. Birthplace Middlesex Co. Va.

16 (a) Informant: Joseph Johnson
(b) Address 1047 W. Fayette St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-11-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location C. A. Co.

18 (a) Funeral director Samuel W. Sullivan
(b) Address 1011 Pennsylvania Ave

19 SEP 11 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1948, at 10:45 P M

21. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained. Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallis M.D.
Medical Examiner.
Date signed 9/11/48

VS 131

666738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G666738

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1644 N. Gilmore St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 1644 N. Gilmore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter B. Watson

3 (b) If veteran, name war WW II

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married last

6 (b) Name of husband or wife: Rebecca Watson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1920

8. AGE: Years 26 | Months 2 | Days 4 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Walter Watson
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie C. Vise
15. Birthplace Md

16 (a) Informant Fannie Watson
(b) Address 1644 N. Gilmore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-46 (month) (day) (year)

(c) Cemetery or crematory Balto nat
Location rvd

18 (a) Funeral director Burgo D. Nelson
(b) Address 1203 Presstman St

19 Filed 9-11-1946 (b) Huntington Williams M.D.
(Date filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1946 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9 1946 to 9/9 1946 and that I last saw h alive on 19

Immediate cause of death Gastro Intestinal Toxic

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged scientifically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer J. Musacchio M.D.

Address 1775 Druid Park Dr Date signed 9/11/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. G66739

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 331 Calvert St,
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn. (b) County
(c) City or town Red Lion
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 W Broadway St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Russell E Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Married

6 (b) Name of husband or wife Mrs Viola A Miller

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Jan 14 1904

8. AGE: Years	Months	Days	If less than one day
44	8	27	hr. min.

9. Birthplace Pennsylvania. (Town, county, and state)

10. Usual Occupation Bank Clerk

11. Industry or business

FATHER
12. Name Covington A. Miller
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mabel Fry
15. Birthplace Pennsylvania.

16 (a) Informant Hospital Records
(b) Address

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof SEPT. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory RED LION CEM.
Location RED LION, PENNA.

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 ST. PAUL ST.

19 SEP 11 1948 Harrington for Williams, M.D. Registrar
(Date filed by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1948 at 7:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 1948 to 9/11 1948, and that I last saw him alive on 9/11 1948.

Immediate cause of death Carcinoma, metastatic, of brain — Duration 6 mo.

Due to Carcinoma, prosto-seminal-rectal area — Duration 6 mo to 9 yrs

Due to

Other Conditions Metastatic carcinoma, bedsores, bilateral
(Include pregnancy within 3 months of death)

Date of operation 9/10/48

Major findings of operation: edema of brain

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Glenn P. Grove M.D.
Address Union Memorial Hospital Signed 9/11/48

VS .150

666740

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 666740

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town Miami - 32 (If outside city or town limits, write RURAL and give town)
(d) Street No. #2 Biscayne Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. George Bullem George Bullen
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Georgianna Bullem
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1887

8. AGE: Years 61 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace Chicago, Ill. (Town, county, and state)

10. Usual Occupation Traffic representative
11. Industry or business Aviation transportation

FATHER
12. Name George Bullem
13. Birthplace Ontario, Canada

MOTHER
14. Maiden Name Lenore Nixon
15. Birthplace Tennessee

16 (a) Informant Mrs. Geo. Bullem
(b) Address #2 Biscayne Blvd. Miami, Fla.

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof Sept. 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodmoor, Md.
Location

18 (a) Funeral director Miller Lawrence
(b) Address 4510 Liberty Heights Ave.

19 SEP 11 1948 (b) for Williams M.D.
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1948 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3, 1948 to Sept. 9, 1948, and that I last saw him alive on Sept. 7 1948.

Immediate cause of death	Duration
Coma uremia due to unknown cause	
Due to Neoplasm of lung, left	3 mo. +
Due to	
Other Conditions pneumonectomy	

(Include pregnancy within 3 months of death)

Date of operation 7-9-48
Major findings of operation: Confirmed above
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Robert Hoare M. D.
Address Church Home & Hospital Date signed 9-9-48

VS 15)

666741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

666741

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2416 Brohawn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2416 Brohawn Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Molly Virginia Collins

Mollie Virginia Collins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife George W. Collins

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Nov-5-1884

8. AGE: Years 63 Months 10 Days 5 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Lathe
13. Birthplace Baltimore

MOTHER
14. Maiden Name Carry Harvey
15. Birthplace Baltimore

16 (a) Informant George W. Collins
(b) Address 2416 Brohawn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director J. Willis Lemmon
(b) Address 4510 Liberty Heights Ave

19 SEP 11 1948 (Date rec'd by Registrar) (b) Signature for Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September-10 1948 at 12 42 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to 9-9- 1948. and that I last saw h e alive on 9-9- 1948.

Immediate cause of death: congestive heart failure — Duration: 2 years

Due to: Cardio Vascular-Renal disease

Due to: Hypertension

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter H. Sonnenfeldt M. D.
Address 2708 Hollins Ferry Rd Date signed 9/10/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

Registered No. 66742

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 S. Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Martinek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-80

8. AGE: Years	Months	Days	If less than one day
67	9	27	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Hackester

11. Industry or business

FATHER
12. Name James Martinek
13. Birthplace Austria

MOTHER
14. Maiden Name Barbara Rytine
15. Birthplace Austria

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Lorraine's Lane

18 (a) Funeral director Lilly & Zeller
(b) Address 1403 S. Caton Ave

19 (a) SEP 11 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20-1948 to 9-8-1948 and that I last saw him alive on 9-8-1948.

Immediate cause of death: Hemorrhage from
Due to: Gastro-intestinal
Due to: Tract (cancer, stated)
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 8/27/48
Major findings of operation:
of autopsy:

Duration: 3 weeks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Thomas V. P. Johns
Address Johns Hopkins Hosp. Date signed 9/7/48

VS 150

666743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

666743 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1203 W 42nd St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 W 42nd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J Fallon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Vera B Fallon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1872

8. AGE: Years 76 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired Salesman

11. Industry or business Pollack & Co

FATHER 12. Name Charles J Fallon
13. Birthplace Baltimore

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Donald W Fallon
(b) Address 4518 Pentwret Ave

17 (a) Burial (b) Date thereof Sept 14 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Lakeside Md

18 (a) Funeral director Harry F Armacost
(b) Address 4204 Rodgers Ave (Funeral Director for Williams, M.D.)

19 (a) SEP 11 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1948, at 6:57 M

21. I certify that I took charge of the remains described above, held an Autopsy & Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Helbrick M.D.
Medical Examiner.
Date signed Sept 16 1948

VS 191

G66744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1278

Registered No. G66744

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Pulaski & Fayette

(c) Hospital or institution: Bon Secour Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore If outside city or town limits, write RURAL and give town

(d) Street No. 339 S. STRICKER St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME MARGARET T. ROCK

3 (b) If veteran, name war

3 (c) Social Security Account No. none

Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Howard Rock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 1- 1864

8. AGE: Years: 84 | Months: 8 | Days: 8 | If less than one day: hr. min.

9. Birthplace: BALTIMORE MD (Town, county, and state)

10. Usual Occupation:

11. Industry or business: HOUSEWIFE

FATHER 12. Name: JOHN C. GERBER

13. Birthplace: Germany

MOTHER 14. Maiden Name: Ann HARRIGAN

15. Birthplace: Ireland

16 (a) Informant: David A. ROCK

(b) Address: 339 S. STRICKER St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: SEPT 13-1948 (month) (day) (year)

(c) Cemetery or crematory: ST VINCENTS

Location: Balto MD

18 (a) Funeral director: Robt C. & B.M. Walker

(b) Address: Pratt & Stricker Sts

19 SEP 11 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7 1948, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1948, to 9-7 1948, and that I last saw h alive on 9-7 1948

Immediate cause of death: Respiratory Failure

Due to: Pulmonary Edema

Due to: Myocardial Insufficiency

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature: [illegible] M.D.

Address [illegible] Date signed 9-11-48

VS 190

G66745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56E

Registered No. G66745

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belwood & green sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Frederick
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 Jefferson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Mullican

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-10-2547

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife not alive Louisa Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 15, 1872

8. AGE: Years	Months	Days	If less than one day
76	0	26	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Retired
11. Industry or business Mechanic

FATHER
12. Name James Mullican
13. Birthplace Md.

MOTHER
14. Maiden Name Victoria Lane
15. Birthplace Md.

16 (a) Informant Mrs Emory shipley
(b) Address 129 W Patrick St, Frederick, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director M. R. Eichelberger & Son
(b) Address Frederick, Md.

SEP 12 1948 (Date rec'd by registrar) Kenneth S. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1948 at 3.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1-1948 to 9-11-1948 and that I last saw him alive on 9-11-1948.

Immediate cause of death	Duration
Coronary thrombosis	
Due to Arteriosclerosis	
Due to	
Other Conditions { Uremia — Benign prostatic Hypertrophy grade II; Papilloma bladder	

(Include pregnancy within 3 months of death)

Date of operation 9/5/48
Major findings of operation BPH grade II Papilloma of bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work):
(Specify)
(e) Means of injury

23. Signature W. A. Wiseman M. D.
Address Univ. Hosp. Date signed 9-11-48

VS 199

X

666746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127a

Registered No. 666746

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balt. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto City
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3332 Fairfield Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Dashiell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: col. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 66 | Months | Days | If less than one day: hr. min.

9. Birthplace Eastern Shore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name George Deshields
13. Birthplace Eastern Shore md

MOTHER
14. Maiden Name Sis Deshields
15. Birthplace Eastern Shore Md

16 (a) Informant Selina Deshields
(b) Address 3332 Fairfield Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 12-48 (month) (day) (year)
(c) Cemetery or crematory Leakin Cem.
Location Eastern Shore Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 100 Bentley ave

SEP 12 1948
(c) (Date rec'd by registrar) Washington Hilliard, Funeral Director

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1948, at 5:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2, 1948, to Sept. 9, 1948, and that I last saw him alive on Sept. 8, 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to ~~Coronary occlusion~~ Myocardial infarction	
Due to Coronary occlusion	
Other Conditions Benign prostatic hypertrophy (Include pregnancy within 3 months of death)	

Date of operation Sept 2, 1948

Major findings of operation: Benign prostatic hypertrophy

of autopsy: none, required

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence. at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marion C. Sheedy, M.D.
Address 1213 Light St Date signed 9/9/48

VS 150

Physicians: please write the causes of death clearly and legibly. Omit age is especially important.

Dr Reg 4-A 166324

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 166747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 - 04 N. Lexington St.
(c) Hospital or institution: Aged Coloured Aged Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Lemprisse Hammond
(b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21 1874

8. AGE: Years	Months	Days	If less than one day
74	7	19	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Inmate
11. Industry or business House for Aged

FATHER 12. Name Charles M. Hammond
13. Birthplace Unknown

MOTHER 14. Maiden Name Julia Johns
15. Birthplace Unknown

16 (a) Informant Mrs L. J. Read
(b) Address 1400-04 N. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 E. Paul St.

SEP 12 1948 (a) (Date rec'd by registrar) (b) Huntington Ave Baltimore

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1948, at 7 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 3-d 1948 to Sept. 10 1948, and that I last saw h/m alive on Sept. 10 1948.

Immediate cause of death Cardio - Respiratory Failure — Duration

Due to Pulmonary Edema, acute

Due to Chronic arteriosclerotic Myocarditis

Other Conditions Coronary Insufficiency

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maryland Edward Day M.D.
Address 4-E-33rd St -18 Date signed 9-11-48

V S 150

Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

Hal 5 666748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 E

Registered No. 666748

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 32 West Chesapeake Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Calvin Trehearn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Seperated

6 (b) Name of husband or wife Edith Trehearn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-12-74

8. AGE: Years	Months	Days	If less than one day
73	9	12	22 hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Trehearn
13. Birthplace Md

MOTHER 14. Maiden Name Marie Campbell
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)
(c) Cemetery or crematory Laurel Hill
Location Laurel Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

SEP 12 1948 (Date rec'd by registrar) waiting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 1948 at 6:35 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1948 to 9/10 1948 and that I last saw him alive on 9/9 1948

Immediate cause of death Respiratory failure — Duration

Due to Uremia

Due to Carcinoma of colon

Other Conditions Postoperative small bowel obstruction
(Include pregnancy within 3 months of death)

Date of operation August 27, 1948

Major findings of operation: Carcinoma of sigmoid colon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard P. Griffith M.D.
Address Johns Hopkins Hospital Date signed 9/10/48

VS 150

X

AB-94159 G66749

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G66749 Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life 32yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 836 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza Gibbons

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 23- 1861

8. AGE: Years 83 | Months 10 | Days 14 17 | If less than one day hr. min.

9. Birthplace [illegible] Pa.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Henry Gibbons
13. Birthplace [illegible] Pa.

MOTHER
14. Maiden Name Emma Fisher (D
15. Birthplace Pennsylvania

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-48 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Elliott City, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St.

SEP 12 1948 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9-1 1948, at 3.15PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-13- 1945 to 9-9- 1948, and that I last saw her alive on 9-9- 1948.

Immediate cause of death Pulmonary edema.

Due to Arteriosclerotic Cardio-vascular Disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

32. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Kirkendall M.D.
Address Balto City Hosp. Date signed 11 Sept 48

VS 150

X

666750

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

666750 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 332 N. Bouth (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE JAMES SMART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 1897

8. AGE: Years 51 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Maine (Town, county, and state)

10. Usual Occupation Laundryman

11. Industry or business St. Josephs Hospital

FATHER 12. Name Alexander Smart

13. Birthplace Canada

MOTHER 14. Maiden Name Alphonsine Pelkey

15. Birthplace Canada

16 (a) Informant Mrs Alphonsine Voight

(b) Address 1704 Dr Sota Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month)

(c) Cemetery or crematory Cathedral

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St Paul St.

19 (a) SEP 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10/48 19 . at 740AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.

Date signed 9/10/48

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 46 G667-51

G667-51

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 65

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Loch Raven, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Loch Raven, Zone 4, Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. KATHERINE SCALLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age (years)

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day
65	—	18	hr. min.

9. Birthplace BALTO. MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name Patrick J. Finn
13. Birthplace Ireland.

MOTHER
14. Maiden Name Catherine Princy
15. Birthplace Balto, Md.

16 (a) Informant Kathryn Parks
(b) Address Loch Raven Rd, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director John Burns' Sons
(b) Address Merton E. Bryant Towson, Maryland

SEP 12 1948 (Date received by registrar) Creighton Williams, M.D. (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1948, at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1948, to Sept 10 1948, and that I last saw her alive on Sept 10 1948.

Immediate cause of death Pseudopneumonia
Paralytic illeus with marked distention

Duration 4 days

Due to Colostomy on Sept 6, 1948

Due to Carcinoma of Rectum with metastasis

7 yrs (?)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation September 6, 1948

Major findings of operation: Carcinoma rectum with liver metastasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury?

23. Signature Emmett M. Smeltzer M.D.
Address Mercy Hospital Date signed 9-10-48

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

66752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. 66752

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 56

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Pa (b) County

(c) City or town Indiana (If outside city or town limits, write RURAL and give town)

(d) Street No. 801 School St. (If rural give location)

(e) Citizen of foreign country? no Yes or No) If yes, name country

3 (a) FULL NAME Joseph Hasinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 18, 1931

8. AGE: Years 17 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Indiana, Pennsylvania (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER 12. Name Mark Hasinger

13. Birthplace Indiana, Pa.

MOTHER 14. Maiden Name Mae Young

15. Birthplace Pa.

16 (a) Informant Mr. Mark Hasinger (Father)

(b) Address 801 School St. - Indiana Pa

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/12/48 (month) (day) (year)

(c) Cemetery or crematory St. Bernards

Location Indiana, Pa

18 (a) Funeral director W. J. Tickner & Sons

(b) Address North & Pa. Ave. - Balto. Md.

SEP 12 1948 (Date rec'd by registrar) Washington Williamson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1948 at 11.50 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1 1948 to Sept 11 1948 and that I last saw him alive on Sept 11 1948

Immediate cause of death: Acute Lymphatic Leukemia — Duration 2 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature [illegible] Dr

Address Mercy Hospital Date signed 9/12/48

V8 190

6667:53

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

6667:53
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 23 (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1838 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Katie L. Kestner

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife C. William Kestner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1866

8. AGE: Years	Months	Days	If less than one day
82	3	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles M. Jackson
13. Birthplace Maryland.

MOTHER
14. Maiden Name Ann Fowler.
15. Birthplace Virginia.

16 (a) Informant Mr. F. C. H. Wessel
(b) Address 4206 Groveland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 12 1948 (Date received by Registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1948, at 4:50 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 9 1948 to Sept. 10 1948, and that I last saw her alive on Sept. 10 1948.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerosis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William S. Womack M. D.
Address Bon Secours Hosp. Date signed 9/10/48

VS 150

66672 ✓ 66672

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2707 Strathmore Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 Strathmore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Eva E. Holloway

3. (b) If veteran, name war: no
3. (c) Social Security Account No.: no

4. Sex: F
5. Color or race: white
6. (a) Single, married, widowed, or divorced: married
6. (b) Name of husband or wife: William Holloway, Sr.
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1875

8. AGE: Years 73 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business

12. (a) Name: Adam Schmidt
12. (b) Birthplace: Baltimore, Md.

13. Maiden Name: Mary M. Grasbinder
14. Birthplace: Baltimore, Md.

15. (a) Informant: Mr. James Holloway
15. (b) Address: 2402 Hamilton Ave.

16. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)
16. (c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

17. (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

18. Filed 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10 1948, at 2 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertension
Cardiac Vascular Disease

Due to

Other Conditions Essential Hypertension

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert E. McClintock M.D.
Medical Examiner
Date signed 9-10-48

42

48-12238
666755

BALTIMORE CITY HEALTH DEPARTMENT ✓ 666755 Registered No.

CERTIFICATE OF DEATH 242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pulaski & Fayette Sts
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 161 W Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA MAE BOWERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8-1948

8. AGE: Years 0 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Raymond W. Bowers
13. Birthplace Balto Md

MOTHER 14. Maiden Name Catherine O. Johnson
15. Birthplace Balto Md

16 (a) Informant Raymond W. Bowers
(b) Address 161 W Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof September 13-1948 (month) (day) (year)
(c) Cemetery or crematory Meadow Branch
Location Westminster Md

18 (a) Funeral director Boyd & B. M. Walters
(b) Address 1501 Stricker St

19 (d) SEP 13 1948 (Registrar)

SEP 13 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 11 1948. at 8-00 H M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 - 29. 1948. to 9 - 11 1948 and that I last saw h m alive on 9-11-48 1948.

Immediate cause of death
Intracranial Hydrocephalus

Due to Brain Tumor
Extensive pyemia with
Due to multiple abscesses

Other Conditions C. P. C. Lungs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:
Brain

of autopsy: Brain Tumor Hydrocephalus

Duration
days

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature C. C. Fisher
Address Bon Secours Hosp Date signed 9-11

I hereby certify that the above is a correct and complete return of the death of the person named herein, as required by the Ordinances of Baltimore City and the Laws of Maryland. Physicians please write plainly.

(66)666756 ✓ 666756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + 33rd St.
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Cooling Ave (If rural, give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Mr. Robert Ruskell Macgill

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 065-03-1396

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife: Mrs. Robert Ruskell Macgill
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1879

8. AGE: Years 69 | Months 7 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Balt. Co., Md. (Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business

FATHER
12. Name William S. Macgill
13. Birthplace New York

MOTHER
14. Maiden Name Josephine McFaul
15. Birthplace Baltimore, Md.

16 (a) Informant Louisa R. Macgill (wife)
(b) Address 517 Cooling Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-48 (month) (day) (year)
(c) Cemetery or crematory Londontown
Location Baltimore

18 (a) Funeral director Shivers & Moore Co.
(b) Address 1080 Mass. Ave.

19 (a) [illegible] (b) Interred by [illegible] (c) Registrar

SEP 13 1948

MEDICAL CERTIFICATION

29. DATE OF DEATH Sept. 9, 1948 at 4:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death: Coronary occlusion — Duration: 3 days
Due to Hypertensive cardio-vascular disease — 8+0 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Coronary occlusion
Hypertensive C-V Disease
Confirmation of autopsy: Generalized

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature H. E. Walters M. D.
Address Union Memorial Hosp. Date signed 9-9-48

66675?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66675?

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida County
(c) City or town Panama City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 32 B. Victoria Circle
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Girl Urban
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced —
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years | Months | Days | If less than one day 44 hr. 9 min.
9. Birthplace Florida (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER FATHER
12. Name John Urban
13. Birthplace Italy
MOTHER
14. Maiden Name Thelma Rebbuna
15. Birthplace Florida

16 (a) Informant:
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal)
(b) Date thereof 9/13/48 (month, day, year)
(c) Cemetery or crematory Pittsfield, Mass
Location Pittsfield Mass

18 (a) Funeral director John O Matchett Son
(b) Address 1220 Eutaw St. Huntington Williamsport, Md

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1948 at 11a M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 11 1948 to Sept 12 1948 and that I last saw h[illegible] alive on Sept 12 1948

Immediate cause of death Respiratory paralysis. — Duration

Due to cardiac failure

Due to Congenital heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not yet complete

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature O'Hanson
Address Johns Hopkins Hospital Date signed 9/12/48

VS 150

666758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Pr Geo.
(c) City or town Rural - Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MAURICE RIDGELY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Edna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/10/[illegible]

8. AGE: Years 49 | Months 7 Mo | Days 28 | If less than one day hr. min.

9. Birthplace Laurel, Pr. Geo Md.
(Town, county, and state)

10. Usual Occupation merchant

11. Industry or business general store

FATHER
12. Name Edward Wm.
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Leizear
15. Birthplace Md

16 (a) Informant J. Robert Frothingham
(b) Address College Park, Md.

17 (a) Burial (b) Date thereof 9/15/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Ivy Hill
Location Laurel

18 (a) Funeral director Dewitt Donaldson
(b) Address Laurel, Md.

19 (a) SEP 13 1948
(Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948 at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1948 to 9-12 1948, and that I last saw h[illegible] alive on 9-12 1948.

Immediate cause of death
Cardio-respiratory failure
Due to Arteriosclerosis
Due to Post operative
Other Conditions Pneumonia
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature W. A. Galambos M. D.
Address Univ. Hosp Date signed 9-12-48

VS 15

X

666759
A 63207

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
5-5E

✓ 666759
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Frederick (If outside city or town limits, write RURAL, and give town)
(d) Street No. 18 E Winchester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laurence Tyeryar -
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-17-96

8. AGE: Years 11 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER 12. Name Chas. Tyeryar
13. Birthplace Md.

MOTHER 14. Maiden Name Catherine Boone
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Frederick - Md.

18 (a) Funeral director C. E. Cline & Son
(b) Address Frederick - Md.

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1948 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5th 1948 to Sept 12 1948 and that I last saw him alive on Sept 12 1948

Immediate cause of death: Streptococcus Pneumonia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature C. E. Stephens M. D.
Address Date signed

VS 150

666760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

Registered No. 666760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1740 h. Gay Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1740 h Gay Street (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Cora V Sproul

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Alfred R Sproul

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 5-3-1891

8. AGE: Years 57 | Months 4 | Days 7 | If less than one day: hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Mc Kay

FATHER — 13. Birthplace Washington D.C

MOTHER — 14. Maiden Name Jane Walker

MOTHER — 15. Birthplace Washington D.C.

16 (a) Informant Alfred R. Sproul

(b) Address 1740 h Gay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-48 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location North Ave & Rose St

18 (a) Funeral director Albert L Stiltz

(b) Address 1106 h Chester Street

19 (a) SEP 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1948, at M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 8 1948, to Sept 10 1948, and that I last saw h e alive on Sept 10 1948.

Immediate cause of death — Duration

Bronchial Tuberculosis

Due to

Due to

Other Conditions Chronic Emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature M. D.

Address 1823 N. Market St. Date signed 9-10-48

VS 150

666761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666761

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 N. Schroeder Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willis GALE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Dora Gale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 10, 1915

8. AGE: Years 33 | Months 7 | Days 28 | If less than one day: hr. min.

9. Birthplace: Maurnsco md (Town, county, and state)

10. Usual Occupation: Oyster - Shucker

11. Industry or business

FATHER
12. Name: William Gail
13. Birthplace: Maurnsco md

MOTHER
14. Maiden Name: Flournie Adams
15. Birthplace: Maurnsco, md

16 (a) Informant: Dora Gale
(b) Address: 103 N. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 13, 1948 (month, day, year)
(c) Cemetery or crematory: Princess Anne
Location: Maryland

18 (a) Funeral director: Mrs Katie R Williams
(b) Address: 312 N. [illegible] St

SEP 13 1948 (b) 0
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 8 1948 at 10:15 A M

21. I certify that I took charge of the remains described above, held an Inspection on the decedent and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature: George A. Merrill M.D.
Medical Examiner.
Date signed 9/8/48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 666762

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1913 Eutaw Place

(c) Hospital or institution: Sunlight Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 29

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 2912 Lonia Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John N Abbott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (c) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Isabella Abbott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24 1864

8. AGE: Years: 84 | Months: 2 | Days: 18 | If less than one day: hr. min. 16

9. Birthplace: Balto (Town, county, and state)

10. Usual Occupation: Butcher Steel (Retired)

11. Industry or business

FATHER

12. Name —

13. Birthplace

MOTHER

14. Maiden Name —

15. Birthplace —

16 (a) Informant: Mrs Albert Aschemeier

(b) Address 2912 Longe Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12/48 (month) (day) (year)

(c) Cemetery or crematory Balto Cem

Location Balto Md

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Orleans St

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1948 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1948 to 19 ; and that I last saw h alive on 9/10 1948.

Immediate cause of death: Suspected cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Karl Trougott

Address 1623 E N Ave Date signed 9/10/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 156 B

Registered No. 666763

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Stockton St. (If rural give location) 1216
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Carter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1941

8. AGE: Years	Months	Days	If less than one day
7			hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Carter
13. Birthplace Frederick Md

MOTHER
14. Maiden Name Addie Wade.
15. Birthplace Frederick Md.

16 (a) Informant Addie Wade Smith
(b) Address 1613 Stockton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location West Port.

18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 927 N. Mount St.

19 SEP 13 1948 (Date received by Registrar) Registrar for Baltimore

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9 1948 at 11 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8 1948 to 9-9 1948 and that I last saw her alive on 9-9 1948

Immediate cause of death Dermatomyositis — Duration

Due to —

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Hardin Jr. M. D.
Address Univ. Hosp. Date signed 9-11-48

VS. 150

X

666764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127B

Registered No. 666764

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 Ruxton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Ruxton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ZELDA Jennie Tralins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Israel
13. Birthplace Russia

MOTHER 14. Maiden Name Debrjah
15. Birthplace Russia

16 (a) Informant Samuel Tralins
(b) Address 1803 Ruxton Ave

17 (a) Burial (b) Date thereof 9-13-48 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Baltimore Hebrew
Location Dolfield Road

18 (a) Funeral director Jacob Lewis Inc
(b) Address 2109 Eutaw Place

19 (a) SEP 13 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1948 at 6 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 1948 to 9/12 1948.
and that I last saw her alive on 9/12 1948

Immediate cause of death Chronic & Subacute Hepatitis — Duration 6 Mo.

Due to Common Bile Duct Obstruction — 6 Mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation MAY 17, 1948

Major findings of operation: Common Bile Duct Obstruction.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward S. Kaelin M.D.
Address 1847 W. North Ave Date signed 9/12/48

VS 150

666765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48

Registered No. 666765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 S. Willard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 S. Willard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Popp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Frank C. Popp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1890

8. AGE: Years	Months	Days	If less than one day
58	9	29	hr. min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Michael Szeck
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs Evelyn Brown daughter
(b) Address 4 S. Willard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13 48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Dorsey, Md

18 (a) Funeral director Harry A Wright
(b) Address 4101 Edmondson Ave

19 SEP 13 1948 (Date rec'd by registrar) Herrington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1948, at 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to Sept. 10 1948, and that I last saw her alive on Sept. 10 1948

Immediate cause of death: Inoperable carcinoma of uterus and extensive involvement of adnexa — Duration: 4 Yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Moore

Address 116 Dulaney Pl. Date signed 9/11/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

066766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 066766

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5202 Gwynn Oak Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5202 Gwynn Oak Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herman Frederick Bartell

3 (b) If veteran, name war

3 (c) Social Security Account No. 577-18-8123

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Ruth ~~Garrett~~ Bartell
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1893

8. AGE: Years	Months	Days	If less than one day
55	-	21	hr. min.

9. Birthplace McDonogh, Md. (Town, county, and state)
10. Usual Occupation Lithographer Engraver
11. Industry or business Dept. of Interior, U.S. Govt

FATHER
12. Name Frantz Herman Bartell
13. Birthplace Berlin, Germany

MOTHER
14. Maiden Name Ellen Jane Redding
15. Birthplace Manchester, Carroll Co., Md.

16 (a) Informant Mrs. Margaret Ruth Bartell
(b) Address 5202 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Miller Guyonnaud
(b) Address 4510 Liberty Heights Ave.

19 (a) SEP 13 1948 (b) [illegible] Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1948, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to 9/11/48 and that I last saw him alive on 9/4/48 19

Immediate cause of death Coronary Occlusion
Due to Cardio vascular renal disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 1 hr. 15 yrs?

Date of operation None
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. U. Harper M. D.
Address 5201 Gwynn Oak Ave Date signed 9/12/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666767

JL - 122798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

Registered No. 666767

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Aval
(c) Hospital or institution:
Baltimore City Hospitals. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 246 S. Conkling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Dorn

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mamie M. Dorn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1877

8. AGE: Years 70 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Balto. City

FATHER
12. Name John Dorn
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret ? ---
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto. Md.

18 (a) Funeral director Philip Murray Sons
(b) Address 2024 Orleans St.

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1948, at 4.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1948 to Sept 10 1948, and that I last saw him alive on Sept. 10 1948.

Immediate cause of death Uremia — Duration 5 days

Due to Bilat pyelonephritis — mos

Due to C B & Nodes — 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/3/47

Major findings of operation: C B & Nodes metastases

of autopsy: bilat pyelonephritis, uremia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M.D.
Address Balt City Hosp. Date signed 9/11/48

VS 150

G66768

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66768

801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2110 ALLENDALE RD~~
(c) Hospital or institution: MARYLAND GEN. HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 ALLENDALE RD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME NORMAN F. DEWLING

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-26-9101

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) AUG 10 1929

8. AGE: Years 19 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation STUDENT

11. Industry or business Cornell College

FATHER
12. Name WALTER F. DEWLING
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY NORMAN
15. Birthplace NEW YORK

16 (a) Informant MOTHER & FATHER
(b) Address SAME AS DECEASED

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md

SEP 13 1948 (Date rec'd by registrar)

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 SEPT 1948 at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 SEPT 1948 to 11 SEPT 1948. and that I last saw h/M alive on 11 SEPT 1948

Immediate cause of death CARDIO-RESPIRATORY FAILURE — Duration —

Due to DIFFUSE ENCEPHALOMYELITIS — Duration 22 days

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

GROSS- SWELLING & DISCOLORATION OF UPPER DORSAL CORD

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald F. England M. D.
Address Maryland Gen Hosp Date signed 11 Sept 48

VS 159

Please write the cause of death clearly and legibly.

666769

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 666769

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 min
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5309 Ready ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary B. Chambers

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George T. Chambers

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1875

8. AGE: Years 73 | Months 7 | Days 16 | If less than one day: hr. min.

9. Birthplace Md. (Frederalsburg)
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER
12. Name Robert Bradley
13. Birthplace Md
14. Maiden Name Mary Noble
15. Birthplace Md

16 (a) Informant Mr. George T. Chambers, husband
(b) Address 5309 Ready Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/48 (month) (day) (year)
(c) Cemetery or crematory Hill Crest Cem.
Location Federalsburg, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Wm. J. Tickner for Wm. J. Tickner, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 / 12 1948. 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1948 to 9/12 1948 and that I last saw her alive on 9/12 1948.

Immediate cause of death Cardiac failure - Cerebral vascular accident

Due to DM - Uremia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. J. Montes, M.D.
Address Church Home Date signed 9/12/48

VS 153

666770
473888

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 53

Registered No. 666770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3703 Spalding, Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edmund Haefner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Bertha M. Haefner

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 4-9-77

8. AGE: Years	Months	Days	If less than one day
71	5	3	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name August Haefner
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Strube
15 Birthplace [redacted] Germany

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/48 (month) (day) (year)
(c) Cemetery or crematory Headowridge
Location Howard Co. Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 13 1948 (Date rec'd by local registrar) (b) [illegible] (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1948 at 2:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9- 1948 to 9-12- 1948
and that I last saw him alive on 9-12- 1948

Immediate cause of death	Duration
Laryngeal edema post operation	
Due to Carcinoma, face & neck glands	6 yrs
Due to	
Other Conditions Diabetes, cirrhosis	

Date of operation Sept 10, 48

Major findings of operation: Squamous carc. face, neck metastasis

of autopsy Laryngeal edema

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J. Handelsman M.D.
Address 1 E. Eden St. Baltimore Date signed 9-12-48

VS 130

G66771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G66771

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga

(c) Hospital or institution: Mercy Hosp. Inc. 19-H

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 264 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1844 W Pratt St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Edwin B. HUGGINS

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	214-22-1801	M	W	Widowed

6 (b) Name of husband or wife Mattie Wilson Huggins 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) JUNE 21-1874

8. AGE: Years	Months	Days	If less than one day
74	2	20	hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name George D. Huggins

13. Birthplace New Jersey

MOTHER

14. Maiden Name Mary Goff

15. Birthplace New Jersey

16 (a) Informant: Mrs Margaret L. Rose

(b) Address 1519 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14-1948 (month) (day) (year)

(c) Cemetery or crematory London Park,

Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.

(b) Address North & Penna Aves Baltimore, Md.

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1948 at 9:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1948 to 9/11 1948

and that I last saw h alive on 9/11 1948

Immediate cause of death Acute peritonitis

Duration

Due to Metastatic lesions

Due to Cancer of neck

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph L. Aronite

Address Mercy Date signed 9/11/48

66672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

Registered No. 66672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. Q. A.
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Ferndale Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WAYSON D. GERWIG

3 (b) If veteran, name war: World War #2

3 (c) Social Security Account No. 220-14-3244

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Beulah Gerwig

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 12, 1924

8. AGE: Years: 24 | Months: 2 | Days: 29 | If less than one day: hr. min

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: -

11. Industry or business:

FATHER
12. Name: Jacob F. Gerwig
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Mabel Downs
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. Jacob F. Gerwig, Jr.
(b) Address: 4111 Newton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 SEP 13 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11, 1948 at 4:50 AM

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gun-shot wound of brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-11-48 at ? A. M.
(b) Where did injury occur? 3015 Ferndale Avenue
(c) Did injury occur at home, on farm, (Address) place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Howard J. Madden M.D. (Medical Examiner)
Date signed 9-11-48

VS 151

666773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666773

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdale Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Finksburg (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALVERDA G. LaMOTTE

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --

6 (c) If Alive, give age years

7. Birth date of deceased: mo., day, yr Oct. 13, 1863

8. AGE: Years 84 | Months 10 | Days 27 | If less than one day: hr. min.

9. Birthplace Finksburg, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Lewis A. J. LaMotte
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Alice H. Stocksdale
15. Birthplace Carroll Co., Md.

16 (a) Informant Dr. W. O. LaMotte, Brother
(b) Address Wilmington, Del.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 12 1948 (Date rec'd by registrar) (b) Tentative for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1948, at 9:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1948, to Sept 10 1948, and that I last saw her alive on Sept 10 1948.

Immediate cause of death: Lobar Pneumonia — Duration: 2.

Due to

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard H. Warner M. D.
Address 2604 Garrison Blvd Date signed 9-13-48.

VS 153

Physicians: please write the causes of death clearly and legibly. Cause of death is especially important. Be sure that the information is complete and correct.

G86774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G86774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 O'Donnell St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 O'Donnell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Bell Kiefer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife: August Kiefer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1876

8. AGE: Years 71 | Months 11 | Days 27 | If less than one day: hr. min.

9. Birthplace Anne Arundel County, Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John Henshaw
13. Birthplace Anne Arundel County, Md.

MOTHER
14. Maiden Name — Ford
15. Birthplace Anne Arundel County

16 (a) Informant Mrs. Wm. Mack
(b) Address 3308 O'Donnell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- 13-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1948 at 4.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 to Sept 8 1948
and that I last saw her alive on Sept 7 1948

Immediate cause of death: Coronary Occlus. — Duration 1/2 hr.
Due to: Arteriosclerosis. — 1 year
Due to: Hypertension.

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J. S. Hardesty M. D.
Address 36 S. Belair Rd Date signed Sep. 11/48

VS 150

066775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 066775

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1431 Patterson Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 5 (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Ins Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma A Kralick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Louis A. Kralick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12 - 1887

8. AGE: Years 61 | Months - | Days 29 | If less than one day hr. min.

9. Birthplace London, England (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Louis Schmidt

13. Birthplace Germany

MOTHER 14. Maiden Name Margaritta P. Bertsch

15. Birthplace Germany

16 (a) Informant Walter W. Kralick

(b) Address 905 Ins Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13-48 (month) (day) (year)

(c) Cemetery or crematory Balto. Cem.

Location North Ave. & Gay St.

18 (a) Funeral director John J. Miller

(b) Address 2334 Jefferson St.

SEP 13 1948 (Date rec'd by registrar)

(c) Huntington Woods Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1948, at 9 P M

21. I certify that I took charge of the remains described above, held an Inq & Insp thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kralick M.D. (Medical Examiner)
Date signed Sept 10, 1948

VS 181

G66776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G66776

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3336 Lyndale Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3336 Lyndale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles E. ~~Wall~~ Wall

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-5856

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Bessie Wall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 - 1882

8. AGE: Years 66 | Months 6 | Days 21 | If less than one day 15 hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired.

FATHER
12. Name Olin Wall
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sophia Fairbank
15. Birthplace Baltimore Md

16 (a) Informant Mrs Bessie Wall
(b) Address 3336 Lyndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Charles P Powell
(b) Address 2727 Edmondson Ave

19 (a) 9-12-1948 (Local registration district) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1948 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1944 to Sept 11 1948 and that I last saw him alive on 9-10 1948.

Immediate cause of death	Duration
Coronary thrombosis	4 yrs.
Due to Generalized arteriosclerosis	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed 9/13/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 190

66777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 66677 Registered No. 958

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd.
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 W Lorraine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Louise G. McKinley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mr. James M. McKinley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1912

8. AGE: Years 35 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Taneytown, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph E. Classon
13. Birthplace Taneytown, Md.

MOTHER 14. Maiden Name Mary Louise Haus
15 Birthplace Baltimore, Md.

16 (a) Informant James M. McKinley
(b) Address 217 W. Lorraine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Baltimore, Md.

18 (a) Funeral director H. A. Ulman and Son
(b) Address 805 N Calvert St.

19 (a) SEP 13 1948 (Date filed by registrar) (b) Huntington Williams, Md. Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1948 at 2:19 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2:14 P.M. to 2:19 P.M., Sept 11 1948 and that I last saw her alive on Sept. 11, 1948.

	Duration
Immediate cause of death Cerebral Embolism	
Due to Rheumatic Heart Disease	8 yrs.
Due to Bacterial Endocarditis	3 wks
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, M.D.
Address Union Memorial Hosp Date signed Sept 11, 48

X

G66778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66778

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 Bethel St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Bethel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) January 7, 1874

8. AGE: Years	Months	Days	If less than one day
74	8	2	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Edward St. Jones

13. Birthplace Md.

MOTHER 14. Maiden Name Annie E. Caldwell

15. Birthplace Md.

16 (a) Informant Zenobia Hollis

(b) Address 2502 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 19 1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park

Location Arbutus Md.

18 (a) Funeral director Mr. Robt A. Elliott Dugle

(b) Address 1129 N. Carrie St.

19 SEP 13 1948 (Date rec'd by registrar) (b) Signature Mr. Robt A. Elliott Dugle, Williamsport, Md.

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1948 at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Sept 9 1948 and that I last saw him alive on Sept 8 1948.

Immediate cause of death	Duration
Myocarditis	?
Generalized arteri-Sclerosis	?
Due to	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benj Thom M. D.

Address 1202 N Carrie St Date signed Sept 13 1948

X

666779

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52 B

Registered No. 666779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004 Bonaparte Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or ~~town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Bonaparte Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis J. Murray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Margaret M. Murray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30 1889

8. AGE: Years	Months	Days	If less than one day
59	5	12	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Agent
11. Industry or business Life Insurance

FATHER
12. Name John C. Murray
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth McDermott
15. Birthplace Balto. Md.

16 (a) Informant Mrs Margaret M. Murray
(b) Address 1004 Bonaparte Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light Street, Balto, Md.

19 SEP 12 1948 (b) (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1948 at 7:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1945 to 9/11 1948 and that I last saw him alive on Sept 11, 1948.

Immediate cause of death Carcinoma of bladder — Duration 1 year

Due to —

Due to —

Other Conditions none
(Include pregnancy within 3 months of death)

Date of operation Aug 21 - 1948

Major findings of operation Confirmed by transitional cell carcinoma of bladder extension through entire wall

Findings of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel M. D.
Address 1226 Hanover St. Date signed 9/11/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1727 Covington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Covington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Barrett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Catherine Barrett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 1863

8. AGE: Years abt. 64 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Barrett
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Vincent J. Barrett
(b) Address 1727 Covington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) SEP 13 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Sept 19 48, at 10:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L Rogers M.D. Medical Examiner
Date signed 12 Sept 48

VS 151

X

666784 - 122342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

136

Registered No. 066781

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 2nd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elliott Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Single ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 25, 1910

8. AGE: Years 37 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Thompson
13. Birthplace S. C.

MOTHER
14. Maiden Name Minnie Robinson
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15. 1948 (month) (day) (year)

(c) Cemetery or crematory Spartanburg. Sc a Cem.
Location Spartanburg. SC.

18 (a) Funeral director Elroy. O. Wilson
(b) Address 1000. Brently. Ave.

19 (a) SEP 13 1948 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

PM

20. DATE OF DEATH Sept. 11, 1948, at 10.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1948, to Sept. 11 1948, and that I last saw him alive on Sept. 11 1948.

Immediate cause of death For advanced bilateral pulmonary tuberculosis with cavities — Duration 6 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M. D.
Address Baltimore City Hosp. Date signed 9-12-48

VS 150

X

666782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 666782

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & 33rd Streets

(c) Hospital or institution Union Memorial Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs 5 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Wyman Pk. Apts. Beech ave (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Kathryn (James) Bradley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife James Bradley

(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1885

8. AGE: Years 63 Months 6 Days 21 If less than one day ___ hr. ___ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation — housewife

11. Industry or business —

FATHER 12. Name Steven Pambrill

13. Birthplace Ellicott City, Md.

MOTHER 14. Maiden Name Kate Gorman

15. Birthplace Howard Co. Md.

16 (a) Informant James Bradley Jr.

(b) Address Wyman Park Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

SEP 14 1948 (Date rec'd by registrar) Huntingtown, Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 19 48 at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 19 48 to 9-12 19 48 and that I last saw her alive on 9-8 19 48.

Immediate cause of death Uremia — Duration

Due to Hypertensive cardiovascular disease

Due to

Other Conditions Left hemiplegia

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John R. Smith, Jr. M. D.

Address Union Mem. Hosp. Date signed 9/12/48

VS 153

6783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. 666783

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St. M.
(c) City or town Ridge (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lucy E. Trimble

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed) or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1891

8. AGE: Years	Months	Days	If less than one day
57	8	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Charles Holbrunner
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Connick
15. Birthplace Md.

16 (a) Informant Admission Card.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Leonardtown, Md
Location Leonardtown, Md

18 (a) Funeral director W. L. Mattingly & Son
(b) Address Leonardtown, Md

19 SEP 14 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 19 48 at 11 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 19 48 to 9-13 19 48.
and that I last saw her alive on 9-13 19 48.

Immediate cause of death Cardiac failure

Due to [redacted] Left ventricular

Due to

Other Conditions Portal Cirrhosis

(Include pregnancy within 3 months of death)
Date of operation 8-28-48
Major findings of operation: Ascites
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. M. Powell M.D.
Address Mercy Hosp Date signed 9-15-48

95c

VS 150

66784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 93

Registered No. 66784

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 313 N. Pulaski Street

(c) Hospital or institution: 20-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 313 N. Pulaski Street
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Forest Linton Lane

3 (b) If veteran, name war None

3 (c) Social Security Account No. 226-14-4860

4 Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nellie T. Lane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) January 30 1888

8. AGE: Years 60 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Berkely Virginia
(Town, county, and state)

10. Usual Occupation Sawyer

11. Industry or business International Elec. Co

FATHER
12. Name Thomas Lane
13. Birthplace Virginia

MOTHER
14. Maiden Name Lela Haskett
15 Birthplace Virginia

16 (a) Informant Mrs. Nellie T. Lane
(b) Address 313 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15-1948 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director George L. Schwab. Frederick Avenue
(b) Address 2101

19 SEP 14 1948 (Date rec'd by registrar) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1948 at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946. to Sept 12 1948.
and that I last saw him alive on Sept 12 1948.

Immediate cause of death (Coronary Thrombosis

Due to Arteriosclerotic Cardiovascular disease

Due to

Other Conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 1 month

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature P. T. Pulaski M. D.

Address 1945 N. Calvert Date signed 9/13/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666785

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

477

666785
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B.C. Co.
(c) City or town [redacted] Glenburnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6th ave N. [redacted] Glen
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Roy Grisbert.
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced M.

6 (b) Name of husband or wife Irene.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1874

8. AGE: Years 73 | Months 11 10 | Days 29 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Retired Printer
11. Industry or business Govt Labor

FATHER
12. Name Michael (died)
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden Name Susan Hann.
15. Birthplace Frederick Co Md (died)

16 (a) Informant Mrs. Irene Husband
(b) Address Glen Burnie

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof SEPT. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 SEP 14 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948 at 1.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1948 to 9-12 1948, and that I last saw him alive on 9-12 1948.

Immediate cause of death Cardiac failure — Duration

Due to Perforated gastric ulcer

Other Conditions Arteriosclerotic cardiovascular disease & grade III chronic nephritis

Ca of lung & massive pleural effusion & metastasis to pleura

Date of operation

Major findings of operation: None

Of autopsy: As a whole

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney J. Venable, Jr. M.D.
Address St. Agnes Hospital Date signed 9-12

117a

65786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 7236

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 308 Prestman St.
(c) Hospital or institution:
1471

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 Prestman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A. Buckner.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife James Buckner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1881

8. AGE: Years 67 | Months 5 | Days 10 | If less than one day: hr. min.

9. Birthplace Greenville, Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Buckner
13. Birthplace Greenville, Va

MOTHER
14. Maiden Name Lottie Smith
15 Birthplace Greenville, Va

16 (a) Informant Mary Lomax
(b) Address 305 Presdman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13, 1948 (month) (day) (year)

(c) Cemetery or crematory Warrenton Va
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroder St

SEP 14 1948 (Date rec'd by Registrar) Christopher Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1948 to Sept 11 1948, and that I last saw h[illegible] alive on Sept 10 1948.

Immediate cause of death Cerebral Hemorrhage

Due to Malig. Hypertension & arterio sclerosis

Due to

Other Conditions Hypertension & arteric heart disease

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed [illegible] 1948

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 66787

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 Ruxton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAX I. GOLDFOSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 187?

8. AGE: Years 75 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace Russia

MOTHER 14. Maiden Name Not Known

15. Birthplace Russia

16 (a) Informant Bert Goydon

(b) Address 1050 No Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-48 (month)

(c) Cemetery or crematory

Location Hebrew Friendship Cem

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Place

SEP 14 1948 (Date rec'd by registrar) Baltimore, Md.

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Sept. 12 1948 at 6:30 M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner

Date signed 9/13/48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. 666788

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hosp 17 DBA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 N. Fremont
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlie Jones

3 (b) If veteran, name war / War I

3 (c) Social Security Account No. Complete

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 10 | Months | Days | If less than one day Hr. min.

9. Birthplace Burgaw. N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Holly Jones
13. Birthplace N. C.

MOTHER 14. Maiden Name Annie Murphy
15. Birthplace N. C.

16 (a) Informant: Charlie Jones
(b) Address 601 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16-48 (month) (day) (year)
(c) Cemetery or crematory Burgaw. N. C.
Location

18 (a) Funeral director James Asbury
(b) Address 1142 Wolfe St.

19 SEP 14 1948 (Date rec'd by registrar) (b) Burial Permit Issued, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Sept 1948 at 12:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12 Sept 48 at 12:30 A.M.
(b) Where did injury occur? 1127 S. Chuke St.
(c) Did injury occur at home, on farm, in industrial place, in public place? Public (While at work) No
(d) Means of injury Shot

23. Signature Earl L. Royster M.D.
Medical Examiner.
Date signed 12 Sept 48

VS 151

X

66789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓ Registered No. 66789

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 E. Hamburg St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 303 E. Hamburg St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosena Appell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1886

8. AGE: Years 61 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Charles H. Appell
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Hudson
15. Birthplace Md

16 (a) Informant Gertrude V. Appell
(b) Address 303 E. Hamburg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director John F. Henny Funeral
(b) Address 714 Light St.

19 (Date received by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1948, at 3 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 7 1948 to Sept 11 1948 and that I last saw h[illegible] alive on Sept 11 1948

Immediate cause of death: acute pulmonary oedema — Duration: 3 days
Due to: chronic myocarditis, 1 year
Due to: senility arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Miller M.D.
Address 124 Aisquith St (Date signed) 9/13/48

VS 150

+

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66790 — 937 — Registered No. 16250

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2519 E. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County QUEEN ANNE'S
(c) City or town Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. Grasonville
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Coursey

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Lilly Coursey
6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.) July 18-1869

8. AGE: Years 79 | Months | Days 25 | If less than one day: hr. min.

9. Birthplace Grasonville Md.
(Town, county, and state)

10. Usual Occupation Oyster dredger

11. Industry or business

FATHER
12. Name "
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Madge Lechner
(b) Address 2519 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Weidner Mill Rd.

18 (a) Funeral director Krause Funeral Home
(b) Address 716 E. Chase St.

19 SEP 14 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12- 1948 at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5- 1948 to 9-12- 1948, and that I last saw him alive on 9-12- 1948.

Immediate cause of death: Chronic myocardial disease — Duration: 5 years

Due to: Arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene B. Nuse M. D.
Address 448 N. Eugene Ave Date signed 9-13-48

VS 180

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied. Use typewriter, black or blue permanent INK.

66791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 ✓

Registered No. G66791

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~MARYLAND GEN~~ 17
(c) Hospital or institution: MARYLAND GENERAL HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 HOURS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County 15 BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 N. PACA ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME OLIVAR BELLAMY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	NEGRO	MARRIED

6 (b) Name of husband or wife Rena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3 1901

8. AGE: Years	Months	Days	If less than one day
46	9		hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation CEMENT WORKER
11. Industry or business

FATHER 12. Name Jack Bellamy
13. Birthplace N.C.

MOTHER 14. Maiden Name Lucinda ?
15. Birthplace S.C.

16 (a) Informant WIFE Rena Bellamy
(b) Address 527 N. Paca St.

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof 9-16-48 (month) (day) (year)
(c) Cemetery or crematory Location Cradbourn N.C.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

SEP 14 1948 (Date rec'd by registrar) (b) Huntington W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 SEPT 1948, at 6:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2:30 PM to 6:35 PM 12 SEPT 1948.
and that I last saw him alive on 12 Sept 1948.

Immediate cause of death	Duration
PULMONARY EDEMA	4 HOURS
Due to HYPERTENSIVE CARDIO VASCULAR DISEASE	FEW YEARS
~~Due to~~ WITH A CEREBRAL HEMORRHAGE	6½ hours
~~Other Conditions~~ AND ACUTE CONGESTIVE CARDIAC FAILURE	4 hours

(Include pregnancy within 3 months of death)

Date of operation NONE
Major findings of operation:
of autopsy Pulmonary edema Cardiac hypertrophy [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald L. England M D
Address Maryland General Hosp. Date signed 12 Sept 48

VS 193

X

66792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. 66792

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
(c) City or town Wildwood Beach, Baltimore #21, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Pierce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Gertrude E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8-1883

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65	1	3		

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Fish Dealer

11. Industry or business

FATHER
12. Name Benj. David Pierce
13. Birthplace Balto. Co. Md

MOTHER
14. Maiden Name Mary E. Frederick
15. Birthplace Md

16 (a) Informant Mrs. Gertrude Pierce
(b) Address Wildwood Beach

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Rd

18 (a) Funeral director John B Connelly
(b) Address 418 Eastern Ave

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) Huntington Woods, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1948 at 3:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1948 to 9/11 1948, and that I last saw him alive on 9/11 1948.

Immediate cause of death: Cardio-respiratory failure — Duration: 1 day

Due to Bronchogenic carcinoma, right lung — 6 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred H. Dann M. D.
Address Maryland Gen'l Hosp. Date signed 9/11/48

VS 150

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

66793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 666793

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. Dukeland st.
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 days
(e) Length of stay in Baltimore (yrs., mos., or days) ~~life~~ 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 South Savage St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME George Horhoe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna Horhoe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15, 1896

8. AGE: Years	Months	Days	If less than one day
52	7	28	hr. min.

9. Birthplace Romania (Town, county, and state)
10. Usual Occupation Loader, Bethlehem S/Co
11. Industry or business

FATHER
12. Name Geo. Horhoe
13. Birthplace Romania

MOTHER
14. Maiden Name Unk
15. Birthplace "

16 (a) Informant Mrs. Anna Horhoe
(b) Address 611 Savage Ste

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 15-48 (month) (day) (year)
(c) Cemetery or crematory Laurel Heights
Location O'Donnell Ste Rd.

18 (a) Funeral director Wm J. Connelly
(b) Address 418 Eastern Ave

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) Washington & Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1948, at 6 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/27 1948, to 8/12 1948 and that I last saw h in alive on 8/11 1948.

Immediate cause of death Malignant Melanoma, source undetermined — Duration Several months

Due to

Due to

Other Conditions Horhoe kidney

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: /

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice W. Davis M. D.
Address W. Balt. Gen. Hosp. Date signed 9-12-48

VS 150

Maurice W. Davis

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66794

BALTIMORE CITY HEALTH DEPARTMENT ✓ 66794 Registered No.

CERTIFICATE OF DEATH 81a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3253 E. Baltimore St.
(c) Hospital or institution: Sydenham Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3253 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Libby

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/19/1940

8. AGE: Years	Months	Days	If less than one day
7	10	22	hr. min.

9. Birthplace Baltimore Md. (Town, county and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Edward Libby
13. Birthplace Eugene Oregon

MOTHER
14. Maiden Name Helen Capet
15. Birthplace St. Augustine, Fla.

16 (a) Informant Mother
(b) Address 3253 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22 1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director John A Horan
(b) Address 3600 E Baltimore St Huntingtown Hillsdale, Md.

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1948 at 9 05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11 1948 to 9/11 1948 and that I last saw him alive on 9/11 1948.

Immediate cause of death: Pneumococcal Meningitis — Duration 1 day.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Goldstein
Address Sydenham Hosp. Date signed 9/10

X

666795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

666795 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital 126
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 N. Clinton Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George Henry Yaekel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, ~~married~~, ~~widowed~~, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-30-76

8. AGE: Years 72 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Sold Papers

11. Industry or business

FATHER 12. Name Conrad Yaekel

13. Birthplace Germany

MOTHER 14. Maiden Name Katherine Singer

15. Birthplace Germany

16 (a) Informant Mrs. Gokes Platt

(b) Address 818 Eutaw Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director John C. Moran

(b) Address 3600 Baltimore St

19 SEP 14 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12/48 1948, at 8 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1948 to 9/12 1948 and that I last saw him alive on 9/12 1948.

Immediate cause of death: Cardio Respiratory Failure

Due to: Hepatic Cirrhosis

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John T. Evans M. D.

Address St. Joseph's Hosp Date signed 9/12/48

VS 150

66796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 666796

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 Druid Hill Ave
(c) Hospital or institution: 14-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 2215 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME JARRETT Edwards MILLER

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7/2/1928

8. AGE: Years	Months	Days	If less than one day
20	2	8	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Newspaper Agent

11. Industry or business

FATHER 12. Name Samuel Miller
13. Birthplace Towson, Md.

MOTHER 14. Maiden Name Coryethia B. Bell
15. Birthplace Baltimore, Md.

16 (a) Informant Coryethia M.S. Mason
(b) Address 2215 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Ann Arundel County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10/48 19 , at 5:38 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26 1948 to 9/10 1948 and that I last saw h[illegible] alive on 9-10 1948.

Immediate cause of death: Broncho-pneumonia — Duration: 2 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature RAYNER BROWNE, M.D.
Address 1500 EAST MADISON ST. BALTIMORE 5, MD.
M.D. Date signed 9/13/48

566797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1318

Registered No. 566797

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 S. Charles St.
(c) Hospital or institution: 23

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1807 S. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence C. Clark.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife — John E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/14/1900

8. AGE: Years	Months	Days	If less than one day
47	10	28	hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Middleton L. King
13. Birthplace Md.

MOTHER
14. Maiden Name Sara E. King
15. Birthplace Md.

16 (a) Informant Family
(b) Address Same.

17 (a) (Burial, cremation, or removal) (b) Date thereof 9-15-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3800 Frederick Rd.

18 (a) Funeral director Jas. L. McCauley
(b) Address 130 S. Fort Ave.

SEP 14 1948 (Date rec'd by registrar) (d) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1948 to Sept 12 1948 and that I last saw h[illegible] alive on Sept 12 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to	
Due to Malignancy	
Other Conditions Chronic Nephritis Osteomalacia	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Schreuer, M.D.
Address 1337 S. Charles St. Date signed 9/13/48

93E

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66798

66798

46 H

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 215 Washburn Ave

(c) Hospital or institution: 25-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 215 Washburn Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Joseph W. Marshall

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-05-8521

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced,
M	W	M.

6 (b) Name of husband or wife Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/30/1883.

8. AGE: Years	Months	Days	If less than one day
65		22	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Con. Oil Co.

FATHER 12. Name Joseph L. W.

13. Birthplace Md.

MOTHER 14. Maiden Name Rosa Byers.

15. Birthplace Md.

16 (a) Informant Family

(b) Address Same

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-15-48 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Brooklyn.

18 (a) Funeral director James L. McCauley

(b) Address 503 Fort Ave.

19 SEP 14 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1948, at 7 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1948 to 9/12 1948 and that I last saw him alive on 9/11/48 19

Immediate cause of death

Typhoid, due to

Due to

Due to Infected malignant ulcer of left leg

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Samuel Rubin M. D.

Address 503 Fort Ave. Date signed

VS 150

Samuel Rubin

66799
444428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. 66799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL, and give town)
(d) Street No. 132 S. High St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Evelyn Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col	married

6 (b) Name of husband or wife James Lewis
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr) 2-24-22

8. AGE: Years	Months	Days	If less than one day
26	6	18	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Newman
13. Birthplace W. Va.

MOTHER
14. Maiden Name Hannah Grimes
15 Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph S. Lords, Jr.
(b) Address 1304 N. Central Ave

19 (a) SEP 14 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 12 - 1948 at 5 - 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5- 1948 to 9-12- 1948 and that I last saw her alive on 9-12- 1948

Immediate cause of death Carcinoma of Cervix — Duration

Due to Vaginal Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 30 1948

Major findings of operation: Carcinoma Terminal & radiation necrosis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, etc.)
(e) Means of injury

23. Signature John Watt Jr.
Address Johns Hopkins Hosp. Date signed Sept 12

VS 150

66800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 66800

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1360 Washington Blvd.
(c) Hospital or institution 21

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1360 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMMER ADELLA HEINER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife: John Jacob Heiner
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 3, 1869

8. AGE: Years	Months	Days	If less than one day
79	7	9	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: George J. Hasfrouss
13. Birthplace: France

MOTHER
14. Maiden Name: Emma S. Longley
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. John J. Heiner, husband
(b) Address: 1360 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1948 at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1940 to Sept 12 1948 and that I last saw him alive on Sept 12 1948

Immediate cause of death: Acute Heart Failure — Duration: 1 day

Due to: Coronary Sclerosis — 6 months

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence: — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature: Louis J. Gaus M. D.
Address: 516 W. Lafayette (516 WASH. BLVD.) (Date signed) 9/13/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66804 U - 86047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Mary Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27. 1853

8. AGE: Years	Months	Days	If less than one day
94	10	17	hr. min.

9. Birthplace Gettysburg, Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Washington Bowen
13. Birthplace Pa. (Gettysburg)

MOTHER
14. Maiden Name Lucy Ann Van Orsdel
15. Birthplace Littlestown Pa.

16 (a) Informant B. C. H. Records
(b) Address 1940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory Evergreen Cem.
Location Gettysburg, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 14 1948 (Date rec'd by Registrar) (b) Registrar

VS 155

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1948 at 10.05 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 18 1944 to Sept. 13 1948. and that I last saw her alive on Sept. 13 1948

Immediate cause of death Bronchopneumonia — Duration 4d.

Due to Senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. T. Nelson
Address BCH Date signed 9/13/48

666802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 666802

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2133 Hollins St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2133 Hollins St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME JOHN W. EMORY.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed.

6 (b) Name of husband or wife: Albertina Emory.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21 1870

8. AGE: Years	Months	Days	If less than one day
78	3	22	hr. min.

9. Birthplace Baltimore - Md.

(Town, county, and state)

10. Usual Occupation Ship Merchant

11. Industry or business Self.

FATHER

12. Name John K. Emory.

13. Birthplace Md.

MOTHER

14. Maiden Name Unknown.

15. Birthplace Md.

16 (a) Informant Mrs. Robert Jones.

(b) Address 2133 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15/48. (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab

(b) Address 3512 Frederick Ave.

SEP 14 1948 (Date rec'd by Registrar) (b) Baltimore Md.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1948 at 10.15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1948 to Sept. 12 1948; and that I last saw him alive on Sept. 12 1948.

	Duration
Immediate cause of death Pneumonia, Lobar.	2 days.
Due to Cerebro Sclerosis	?
Due to Arterio Sclerosis C. V. Disease.	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Samuel E. Bozorad M. D.

Address 1405 W. Baltimore Date signed 9/14/48

66803 ES-122882

CERTIFICATE CORRECTED 9-1-50 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 666803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals. 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Boehm

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	D.

6 (b) Name of husband or wife Alice Boehm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 27, 1883

8. AGE: Years	Months	Days	If less than one day
64 (65) 64	9	16	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Boehm
13. Birthplace Germany

MOTHER 14. Maiden Name Josephine Christ
15. Birthplace Germany

16 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Fulton & Lord
(b) Address 1217 W. Lord St.

SEP 14 1948 (Date rec'd by registrar) (b) Washington Boulevard

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12-48 1948, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12-36 1936 to 9-12 1948, and that I last saw him alive on 9-12- 1948

Immediate cause of death (a) Fulminating carcinoma bilateral tuberculosis & cavitation (over)

Duration years -

Duration (b) 2 ary Carcinomatosis liver & primary pit probably rectum (?)

Other Conditions Adenocarcinoma of stomach

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy ABOVE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Warren E. Porter
Address Balto. City Hospitals Date signed M 9 D 13/48

G66804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

✓ G66804 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~701 E. Melville Ave.~~
(c) Hospital or institution: Mercy Hospital Balto Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto #18, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 E. Melville Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Bleach.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-3238

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married.

6 (b) Name of husband or wife Lottie Bleach.
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr) Oct 6, 1873.

8. AGE: Years	Months	Days	If less than one day
74	11	6	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)

10. Usual Occupation Watchman.
11. Industry or business Coal Sq. Brewing.

FATHER
12. Name John. Bleach.
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Herwig
15. Birthplace Germany

16 (a) Informant Lottie Bleach
(b) Address 701 E. Melville Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Oak Lawn
Location Eastern Ave - Local

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 SEP 14 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1948, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1948, to Sept 12 1948, and that I last saw him alive on Sept 12 1948:

Immediate cause of death	Duration
Cerebro-vascular Accident - probably cerebral thrombosis.	4 days
Due to	
Due to	
Other Conditions Carcinoma of Large Bowel - resected (Include pregnancy within 3 months of death)	2 yrs.

Date of operation None
Major findings of operation:
of autopsy: Hypernephroma left kidney with metastases.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. M. Brucer M. D.
Address Mercy Hospital Date signed 9/13/48

VS 150

83a

66805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171a

Registered No. 66805

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hosp. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3515 Third st. Brooklyn
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Wehgartner (JOSEPH WEHGARTNER)

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-14-0606

4. Sex M | 5. Color or race W | 6 (a) ~~Single, married, widowed, or~~ divorced. Divorced

6 (b) Name of ~~husband or~~ wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18th 1886

8. AGE: Years 62 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Watchman - Guard

11. Industry or business Jones Distillery

FATHER
12. Name (Unknown) Wehgartner
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Dorothea Kozzybski
(b) 3515 Third st. - Brooklyn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/48 (month)

(c) Cemetery or crematory Holy Cross
Location a. a. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St.

19 (a) SEP 14 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1948 at 5 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull & cerebral Hemorrhage

Due to

Other Conditions Hemorrhage A.S.C.D. Diabetes -
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3 Sept 48 at 2 P. M. 26/6
(b) Where did injury occur? Walter's Crossing Waiting station (Lombard's Crossing) (Canton)
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? NO
(d) Means of injury Struck by #26 Streetcar

23. Signature Earl [illegible] M.D.
Medical Examiner
Date signed 12 Sept 48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 85

Registered No. 666806

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1527 Edmondson Ave.
(c) Hospital or institution: 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN BERKLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M		

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1932

8. AGE: Years	Months	Days	If less than one day: hr.	min.
16	6	2		

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John J. Berkley, Sr.
13. Birthplace Lousville, Kentucky

MOTHER
14. Maiden Name Viola King Brkley
15. Birthplace Montgomery Co., Md.

16 (a) Informant Viola Berkley
(b) Address 1527 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St
Baltimore Maryland

19 (a) 14 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep. 10 1948 at 11:30 A M

21. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema

Due to

Other Conditions Epilepsy
(Include pregnancy within 3 months of death)

22. If external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Thomsen M.D.
Medical Examiner.
Date signed 9/10/48

VS 151

1116

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61.

Registered No. G66807

Physicians: please write the causes of death clearly and legibly. Be sure that the age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 310 N. Pulaski Street
(c) Hospital or institution: ********** 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) ****
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Pulaski Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH R. BROWN

3 (b) If veteran, name war ********

3 (c) Social Security Account No. **********

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife JAMES H. BROWN
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) JUNE 16- 1873

8. AGE: Years	Months	Days	If less than one day
75	2	27 26	********** min.

9. Birthplace QUEEN Ann County Md.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business AT HOME

FATHER 12. Name	THOMAS DELAHAY
FATHER 13. Birthplace	MARYLAND
MOTHER 14. Maiden Name	ARRIANNA PORTER
MOTHER 15. Birthplace	MARYLAND

16 (a) Informant MRS. ARRIE A. GRIFFISS
(b) Address 516 CHARING CROSS ROAD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 14-48 (month) (day) (year)
(c) Cemetery or crematory MEADOW RIDGE MEMORIAL
Location DORSEY . . MARYLAND

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE....17

SEP 14 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH SEPTEMBER 12 19 48 at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 19 46 to Sept 11 19 48 and that I last saw her alive on Sept 11 19 48

Immediate cause of death: Cerebral thrombosis

Due to Arterio sclerosis + diabetes mellitus.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 days / Several yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Bowman Hood
Address 2200 CARRISON BLVD. Date signed 9/13/48 M. D.

VS 150

Dr. Bowman Hood. X

66808 2603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 66808 Registered No. 121a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Hilkens
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2709 Hilkens Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: FRANCIS NORMAN BALDWIN
3 (b) If veteran, name war: No.
3 (c) Social Security Account No. 215-10-7058

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Marie E.
6 (c) If alive, give age 52 years
7. Birth date of deceased (mo., day, yr) MAR-26-1894

8. AGE: Years	Months	Days	If less than one day
54	5	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Bar Tender
11. Industry or business Bleb Tavern

FATHER
12. Name Howard Baldwin
13. Birthplace Md

MOTHER
14. Maiden Name Catherine O'Donnell
15. Birthplace Md

16 (a) Informant Marie E. Baldwin wife
(b) Address 2709 Hilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director F. B. Hubert & Son
(b) Address 130 E. Eutaw Place

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948, at 11 29 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-9 1948, to 9-12 1948, and that I last saw h[illegible] alive on 9-12 1948.

Immediate cause of death: Cardio resp failure — Cerebral hemorrhage — Duration

Due to Hypertension - CVD

Due to renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney J. Umble MD M. D.
Address St. Agnes Hospital Date signed 9-12

666809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 666809

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1044 Stockton St.
(c) Hospital or institution:
16 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1044 Stockton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Sydnor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Kezia Sydnor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 12 1874

8. AGE: Years 73 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Lancaster Co. Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Spencer Sydnor
13. Birthplace Lancaster Co. Va.

MOTHER
14. Maiden Name Fannie
15 Birthplace Lancaster Co. Va.

16 (a) Informant Randolph Sydnor
(b) Address 1312 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14, 1948. (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie L. Williams
(b) Address 322 N. Schroeder St.

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1948, at 9:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1948 to Sept 10 1948
and that I last saw h[illegible] alive on Sept 10 1948

Immediate cause of death: Pulmonary Embolism — Duration: 1 day

Due to: Fractured r. subtrochanteric N. of Leg. — Duration: 3 wks

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: N+1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 8-28-48 at ? M
(c) Where did injury occur? 1044 Stockton St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Stumbled + fell to floor

23. Signature J. Garland Shirell M.D.
Address 102 W. Franklin Date signed 9-14-48

Howard J. Madden, M.D. ×

666810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

666810 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31 St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County Philadelphia
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 5445 Westminster Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WAVERLY ALEXANDER TAYLOR

3 (b) If veteran, name war: VA 2

3 (c) Social Security Account No. 217-18-0485

4. Sex: M

5. Color or race: col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Joy Taylor

6 (c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.) April 29, 1922

8. AGE: Years 26 | Months 4 | Days 25 | If less than one day: 4 hr. min.

9. Birthplace: Meredethville, Va. (Town, county, and state)

10. Usual Occupation: Student

11. Industry or business

FATHER
12. Name: Montford Taylor
13. Birthplace: Va.

MOTHER
14. Maiden Name: Harriet
15. Birthplace: Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Nat'l. Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Mrs. Emma V. Holland
(b) Address: 1631 Druid Hill Ave.

19 (a) SEP 14 1948 (Date received by Registrar) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1948, at 2:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1948, to Sept. 13 1948, and that I last saw him alive on Sept. 13 1948.

Immediate cause of death Carcinoma of right lung with metastases — Duration: About 3 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Van Acoren, Medical Director
Address Medical Officer in Charge Date signed 9/13/48

VS 159

66811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 J

Registered No. 66811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos 24 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos 24 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Lombardee Beach (If outside city or town limits, write RURAL, and give town)
(d) Street No. Glen Burnie, P.O. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ella L. Evans

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
F.	W.	Widow

6 (b) Name of husband or wife Charles V. Evans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30-1885

8. AGE: Years	Months	Days	If less than one day hr.	min.
62	10	13	14	

9. Birthplace Maryland (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Granville Myers
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Wine
15. Birthplace Pennsylvania

16 (a) Informant Ella Evans (deceased)
(b) Address Charles L. Daily - Glen Burnie, P.O.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16-1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3021 Falls Road

19 (a) SEP 14 1948 (Date rec'd by registrar) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 19 . at 2.30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 2 1948 to Sept 13 1948 and that I last saw h[illegible] T alive on 19

Immediate cause of death	Duration
Resp arrest	
Due to adenocarcinoma of rectum with metastases to liver and epitrochlear nodes	
Due to Benign essential hyper[illegible]	
Other Conditions Poor [illegible]	

(Include pregnancy within 3 months of death)

Date of operation 5/28/48
Major findings of operation: Adenocarcinoma of rectum with metastases to liver and epitrochlear nodes
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify public place)
(e) Means of injury

23. Signature J. A. Kantner M. D.
Address 1 E Fayette Street Balto 1, Md
Date signed 9/13/48

VS 150

66812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124C

Registered No. 66812

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., ~~days~~) 3½
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5506 Park Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Katherine A. Upton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife John E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-30-01

8. AGE: Years 47 | Months 4 | Days 15/24 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Wm E. Manick
13. Birthplace Balto Md

MOTHER 14. Maiden Name Anna Latier
15 Birthplace Balto Md

16 (a) Informant Mrs Esther Fisher (sister)
(b) Address 2860 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/48 (month, day, year)
(c) Cemetery or crematory Balto Natl Cem
Location 5501 Frederick Ave

18 (a) Funeral director John J. Conway & Son
(b) Address 901-03 Hollins St.

19 SEP 14 1948 Huntington Williams, M.D. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 17 1948, at 7:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5 21 1948 to 9 14 1948, and that I last saw her alive on 9 17 1948.

Immediate cause of death	Duration
Heart Failure acute	
Due to Pulmonary edema	1 hr
Due to Portal cirrhosis of liver	6 mos.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9-10

Major findings of operation: Portal cirrhosis, Ascites

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature Harry V. Chase (or Judd M.D.)
Address Mercy Hospital Date signed 9-17

VS 150

666813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

836

Registered No. 666813

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3628 Elm Ave.
(c) Hospital or institution:

13-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3628 Elm Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Levi C. Buffington.

3 (b) If veteran, name war ----

3 (c) Social Security Account No. -----

4. Sex: Male.

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Phoebe Buffington.

6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1860

8. AGE: Years 88 | Months 8 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Foreman, Retired.

11. Industry or business Textile Mills.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Phoebe Buffington.
(b) Address 3628 Elm Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Sept. 16/48 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden.

18 (a) Funeral director Paul E. Chenoweth Jr.
(b) Address 3615-17 Chestnut Ave.

19 (a) SEP 14 1948 (Date rec'd by registrar) Huntington-Williamson, Inc

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1948. at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1948. to Sept 13 1948. and that I last saw h/m alive on Sept 13 1948.

Immediate cause of death: Cardio respiratory failure — Duration

Due to Cerebral Hemorrhage

Due to Arteriosclerosis

Other Conditions Senility.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Williams M. D.

Address 846 W 34th St Date signed Sept 14 48

VS 180

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

666814

BALTIMORE CITY HEALTH DEPARTMENT
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registered No. 666814

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hyman Pk. Dr. & 31st St.
(c) Hospital or institution: U. S. Marine Hospital 13-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) ? mos.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Keswick Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice Edmund SCUDDER

3 (b) If veteran, name war WW II

3 (c) Social Security Account No. 215-24-5569

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1928

8. AGE: Years 20 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace Binghamton, N.Y. (Town, county, and state)

10. Usual Occupation Quilter.

11. Industry or business Mat. Bedding Co.

FATHER
12. Name Charles Scudder
13. Birthplace Fla.

MOTHER
14. Maiden Name Mildred Ann Rackett
15. Birthplace N.Y.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Sept 15, 48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park.
Location

18 (a) Funeral director Paul E. Chenoweth Jr.
(b) Address 3615-17 Chestnut Ave.

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12, 1948, at 4:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24, 1948, to Sep 12, 1948, and that I last saw him alive on Sep 12, 1948.

Immediate cause of death: Tuberculous meningitis — Duration: ?

Due to: Tuberculous spondylitis — Duration: 1 yr.

Due to:

Other Conditions: none

(Include pregnancy within 3 months of death)

Date of operation Apr 20, 1948

Major findings of operation: as above

of autopsy: none

PHYSICIAN
(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. G. Morrow, M.D.
Address Marine Hospital Date signed 9/12/48

VS 150

AC-41-1492

BALTIMORE CITY HEALTH DEPARTMENT

666815

66815 BC-48-14208 A. 644 19208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

✓ 66815 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 N. Spring Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Rucker - ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7-8-48

8. AGE: Years 2 | Months | Days 3 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Chas. Rucker
13. Birthplace Va. -

MOTHER 14. Maiden Name Dorothy Lawrence
15. Birthplace S. C. -

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Baltimore Md

18 (a) Funeral director Elroy Fuller
(b) Address 1001 Bentley Ave Washington Ave

19 SEP 14 1948 (Date filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1948 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1948 to Sept 11 1948 and that I last saw h alive on Sept 11 1948

Immediate cause of death: Convulsions — Duration

Due to Cerebral anoxia secondary to

Due to Shock associated with acute Diarrhea

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Cerebral Edema

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Mitchell Marchant M. D.
Address Johns Hopkins Date signed 9-13-48

VS 150

666816 Dr. Merrill on Vacation ✓ 666816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193

Registered No.

Be in Monday 9/12/48

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7420 Brightside Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Enrico (Henry) Gabriele

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-2728

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of wife: Elizabeth M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7 1895

8. AGE: Years 52 | Months 9 | Days 4 | If less than one day: hr. min

9. Birthplace: Teramo Italy
(Town, county, and state)

10. Usual Occupation: Forman

11. Industry or business

FATHER
12. Name: Beniamino Gabriele
13. Birthplace: Italy

MOTHER
14. Maiden Name: Virgilia Giacomelli
15. Birthplace: Italy

16 (a) Informant: Elizabeth M. Gabriele (Wife)
(b) Address: 7420 Brightside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15/48 (month)

(c) Cemetery or crematory: New Cathedral
Location: 4300 Old Frederick Rd.

18 (a) Funeral director: Frank Dell's Sons
(b) Address: 322 S. High St.

19 (a) SEP 14 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute congestive cardiac failure probably
Due to electric shock
Other Conditions Fract. left tibia & fibula
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-11-48 at 10:30 a. M.
(b) Where did injury occur? Windsor Lane, Catonsville
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? yes
(d) Means of injury Contact with live wire

23. Signature E. Merrill M.D.
Medical Examiner.
Date signed 9/11/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

666817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. 666817

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): less than 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1535 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: RAYMOND CHARLES WELLS

3 (b) If veteran, name war: Va 2

3 (c) Social Security Account No.: ?

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 26, 1899

8. AGE: Years: 48 | Months: 8 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation: Conductor

11. Industry or business:

FATHER
12. Name: John D. Wells
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Baum
15. Birthplace: Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 15/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Pk.
Location: 3801 Frederick Rd

18 (a) Funeral director: Harry H. Wintzfe
(b) Address: 4/ Edmondson ave

19 (a) SEP 14 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 12 1948, at 4:40P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1948, to Sept. 12 1948, and that I last saw h im alive on Sept. 12 1948.

Immediate cause of death: Hemorrhage from esophageal varices — Duration: 12 hrs.

Due to:

Due to:

Other Conditions: Laennec's cirrhosis — Unknown
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: J.F. van Ackeren, Medical Director
Address: Medical Officer in Charge Date signed 9/13/48

VS 150

100a

GC 695674 G66818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G66818

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital 23-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Patapsco Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sharron C. Sterry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/2/47

8. AGE: Years	Months	Days	If less than one day
	9	11	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Warren Sterry
13. Birthplace Virginia

MOTHER
14. Maiden Name Catherine Crook
15. Birthplace Maryland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross.
Location Baltimore Highlands

18 (a) Funeral director Martin J. Gormley
(b) Address 1825 W. Fayette St.

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13/48 19 , at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13/48 19 , to 9/13/48 19 , and that I last saw her alive on 9/13/48 19

Immediate cause of death: Meningitis and Bilateral Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: see above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Hawn M. D.
Address South Balto Gen Hosp Date signed Baltimore 30, Md 9/14/48

VS 150

666819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address. Coal Pier, 2200 S. Clinton St.
(c) Hospital or institution: (Found floating in harbor)

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown Baby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			hr. ? 5 min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School SEP 14 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 14 1948 (Date rec'd by registrar) (b) Washington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1948, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, ~~undetermined~~ ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Undetermined

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Rogow M.D.
Medical Examiner
Date signed 7/24/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

586820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

184

Registered No. 66820

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard and Greene Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Harve de Grace Rt. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel F Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife ———

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 - 1938

8. AGE: Years 10 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Severna, Md
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business at school

FATHER 12. Name Daniel F. Hill

13. Birthplace Va

MOTHER 14. Maiden Name Doris Medley

15. Birthplace Va

16 (a) Informant Daniel F Hill

(b) Address Rt. 2 Harve de Grace Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-48 (month) (day) (year)

(c) Cemetery or crematory Angel Hill

Location Harve de Grace

18 (a) Funeral director Pennington & Son

(b) Address Harve de Grace Md

19 SEP 15 1948 (Date rec'd by registrar) Cullington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948 at 12.05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intercranial Hemorrhage - Compound Fracture of the Skull

Due to Gun shot wound of the skull

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-11-48 at 1.30 P.M.

(b) Where did injury occur? Harve de Grace

(c) Did injury occur at home, on farm, industrial place, in public place? Home (yard) While at work? No

(d) Means of injury Shipped and fell over bed striking head

23. Signature Robert B. McFadden M.D.
Medical Examiner.

Date signed 9-12-48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124A

Registered No. G66821

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town Miami (If outside city or town limits, write RURAL and give town)
(d) Street No. ? (If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Edw Don Jordan~~ Edward Don Jordan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	(M)

6 (b) Name of husband or wife Nellie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) aug. 11. 1888

8. AGE: Years 60 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation none.

11. Industry or business

FATHER 12. Name Thomas Don Jordan

13. Birthplace

MOTHER 14. Maiden Name Fronia Jacobs

15. Birthplace

16 (a) Informant wife

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Location Baltimore Md

18 (a) Funeral director Tilburn Cook Inc

(b) Address 1219 E Fort Ave

19 SEP 15 1948 (Date received by registrar) (b) Contractor for Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12-48 19 , at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8-48 19 , to 9-12-48 19 ; and that I last saw him alive on 9-12- 19 .

Immediate cause of death Resp failure

Duration

Due to: cirrhosis of liver
Due to: Dehydration
Chronic alcoholism
Other Conditions: Pulmonary edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Hahn M. D.

Address University Hosp Date signed 9-13-48

X

66822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 666822

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 W Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 W Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur Talbott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1948, at 10:55 P M

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Sophia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-12-1851

8. AGE: Years 66 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Hat Blocker

11. Industry or business New England Hat Co

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Frank Dyerbaugh
(b) Address 506 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral [redacted]
Location Baltimore - Md

18 (a) Funeral director William Cook Inc.
(b) Address 1119 St Paul St

SEP 15 1948 (Date) received by Registrar Huntington Williams, M.D.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of Colon
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S Selbach M.D.
Medical Examiner.
Date signed Sept 14, 1948

VS 151

66823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 f

Registered No. 668223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd
(c) Hospital or institution: Haven Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2034 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice J. Toney

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Widow

6 (b) Name of husband ~~or wife~~ Geo. W.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Aug 10. 1869

8. AGE: Years 79 | Months 1 | Days 3. | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. D. Smith
13. Birthplace Balto.

MOTHER
14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Mrs. "Elsie" Buckingham
(b) Address 529 N. Belnord Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16, 48 (month) (day) (year)
(c) Cemetery or crematory Bulls Church
Location North Ave Ext

18 (a) Funeral director Agnes M. Sutton
(b) Address 1203 No. Broadway

SEP 15 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13. 1946 at 6:25 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 7/13/48 to 9/13/48. and that I last saw her alive on 9/12/48

Immediate cause of death Carcinoma of Liver

Duration 2 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. Wessendorf M.D.

Address 1427 E. North Ave Date signed 11/14/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66824 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Fremont ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 N. Fremont ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alonzo Johnson

3 (b) If veteran, name war: War 1

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1894

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name Alonzo Johnson

13. Birthplace md

MOTHER 14. Maiden Name Elizabeth Douglas

15. Birthplace md.

16 (a) Informant Beatrice Christy

(b) Address 601 N. Fremont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16-48 (month) (day) (year)

(c) Cemetery or crematory Bunker Hill Cem

Location Annapolis, md

18 (a) Funeral director Jamie Arnaya

(b) Address 142 West St

19 (a) SEP 15 1948 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1948 at 4.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1947 to Sept 13 1948, and that I last saw h[illegible] alive on Sept 13 1948

Immediate cause of death: Coronary Thrombosis — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 9-15-48

Charles F. Woodland

Medical & Chemical Case

Released by medical examiner

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186A

Registered No. 666825

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland St. and Fayette Ave.
(c) Hospital or institution:
West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Maine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph S. Ferguson FERGUSON.

3 (b) If veteran, name war none

3 (c) Social Security Account No.

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced. widower

6 (b) Name of husband or wife Edna K. Ferguson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1888

8. AGE: Years 59 | Months 10 | Days 0 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Wm. M. Patterson Co.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. E. Marjorie Towson
(b) Address 2903 Lyndhurst Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9/15/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 15 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 19 48, at 1:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 19 48, to Sept 14 19 48, and that I last saw him alive on Sept. 14 19 48.

Immediate cause of death	Duration
Cardio-pulmonary failure	
Due to Fr Intracranial hemorrhage	
Due to Fractured skull	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept. 11 '48

Major findings of operation: Fractured skull & intra-cranial hemorrhage

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Sept. 10th at ? M
(c) Where did injury occur? Balto (City or town) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down steps (inside)

23. Signature Katharine F. Kemp M. D.
Address West Balto. Gen. Hosp. Date signed Sept. 14, 1948

VS 150

William H. Kammer, Jr., M.D. per: Earl Kemp

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G66826

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 No Smallwood St
(c) Hospital or institution: 15-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1804 No Smallwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Shapiro

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Myer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 1873

8. AGE: Years: 75 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Meyer
13. Birthplace: Russia

MOTHER
14. Maiden Name: Goldie
15. Birthplace: Russia

16 (a) Informant: Meyer Shapiro
(b) Address: 1804 No Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-48 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Location: Philadelphia Rd & Hamilton Ave

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2100 Eutaw Place

19 (a) SEP 15 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14- 1948, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to 19 , and that I last saw h alive on Apr. 14 1948.

Immediate cause of death: Pulmonary edema
Cardiac failure
Duration:

Due to: Arteriosclerotic Cardiosclerosis
Due to: Chronic Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. G. Kessler M. D.

Address 814 W. North Ave Date signed 9/15/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66827

BALTIMORE CITY HEALTH DEPARTMENT 94A Registered No. 66827

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Always

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ...
(c) City or town Rural - Pasadena (If outside city or town limits, write RURAL and give town)
(d) Street No. Creek Drive, Rockhill Beach (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ...

3 (a) FULL NAME Elzey L. Sank

3 (b) If veteran, name war ...
3 (c) Social Security Account No. ...

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Margaret M.
6 (c) If [illegible], give age ... years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1881

8. AGE: Years 66 | Months 11 | Days 19 | If less than one day: hr. ... min. ...

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired
11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Son - Mr. Sank
(b) Address 2 Clearwater Beach Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie, Md.

18 (a) Funeral director Harry H. Little
(b) Address 4101 Edmondson Ave

19 (a) SEP 15 1948 (Date rec'd by registrar) (b) Huntington Ellicott, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1948, at 2 30 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-11 1948 to 9-12 1948, and that I last saw h[illegible] alive on 9-12 1948

Immediate cause of death	Duration
Acute Pulmonary Edema	5 hr.
Due to Anterior Myocardial Infarct.	3 days
Due to (Extension) Coronary Thrombosis	3 days

Other Conditions ...
(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operation: ...
of autopsy: Anterior Myocardial Infarct

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. Powell M. D.
Address 1213 Light St. Date signed 9-12-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

66828 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 Eutaw Place 28
(c) Hospital or institution: Balto. Eye Ear & Throat Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life 78 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and name town)
(d) Street address (or rural give location) 1225 Arlington Ave. Spiritual German Aged People's Home
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3. (a) FULL NAME Henry Conrad Fredrich Bergen.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married.

6 (b) Name of husband or wife Sophie Fisher.
6 (c) If alive, give age 76 years
7. Birth date of deceased (mo., day, yr.) 1-3-70.

8. AGE: Years	Months	Days	If less than one day
78	11	8	hr. min.

9. Birthplace Baltimore City. (Town, county, and state)
10. Usual Occupation Retired Tailor.
11. Industry or business Tailor.

FATHER
12. Name Eberhard Bergen
13. Birthplace Germany.

MOTHER
14. Maiden Name Amalie Fuchs
15. Birthplace Germany.

16 (a) Informant Wife.
(b) Spiritual German Aged People's Home of Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17-48 (month) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn
18 (a) Funeral director Tracy H. Wilson
(b) Address 1101 Edmondson Ave.
19 (a) SEP 15 1948 (Date rec'd by registrar) (b) Filed by Wm. A. Mc

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1948. at 8 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1948. to Sept 14 1948 and that I last saw him alive on Sept 14 1948.

Immediate cause of death	Duration
Cardiac decompensation	
Due to Chronic Myocarditis	
Due to	
Other Conditions Fell Out of Bed Contusion Left Eye Following Cataract Extraction Left Eye (Include pregnancy within 3 months of death)	

Date of operation Sept 9. 1948
Major findings of operation: Mature Cataract - Left Eye -
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Mayo Posey M.D. (Attending) Eye Ear Throat Date signed Sept 14 - 48
Address 1214 Eutaw Place

VS 8

666829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 666829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 S. MONROE ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20+
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 S. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GARLAND H. MARTIN SR

3 (b) If veteran, name war

3 (c) Social Security Account No. 211-01-8849

4. Sex MALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife MARIE V. MARTIN

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) DECEMBER 16-1889

8. AGE: Years 58 | Months 8 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace CHARLES TOWN W. VA (Town, county, and state)

10. Usual Occupation MEAT CUTTER

11. Industry or business

FATHER
12. Name Richard N. MARTIN
13. Birthplace Virginia

MOTHER
14. Maiden Name ANNIE R. WILLIAMS
15. Birthplace Maryland

16 (a) Informant MARIE V. MARTIN
(b) Address 410 S. MONROE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 17-1948 (month) (day) (year)
(c) Cemetery or crematory Edgehill Cem.
Location Charles Town W. Va

18 (a) Funeral director J. C. & B. M. Walters
(b) Address Pratt & Strieker Sts

19 SEP 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 14 1948 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1947 to 9/14 1948 and that I last saw him alive on 9/14 1948.

Immediate cause of death Carcinoma of colon — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation May 11, 1948

Major findings of operation: Carcinoma of colon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence , at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address US 30 Wilkes Date signed 9/14/48

VS 150

66830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. 66830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 N. GILMOR ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19+
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA MAUDE WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	C	Married

6 (b) Name of husband or wife John Williams (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1906

8. AGE: Years	Months	Days	If less than one day
42	3	-	hr. min.

9. Birthplace Essex County, Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Buckley, Noel
13. Birthplace Virginia

MOTHER
14. Maiden Name Hattie Carter
15. Birthplace Va.

16 (a) Informant Maggie Waller
(b) Address 406 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 W. Lanvale St

19 SEP 15 1948 (Date rec'd by registrar) (Signature of registrar) Hunter Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1948, at 8:12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11 1948, to 9-13 1948, and that I last saw h[illegible] alive on 9-11 1948.

Immediate cause of death RUPTURED ABDOMINAL AORTIC ANEURYSM — Duration

Due to ABDOMINAL AORTIC ANEURYSM — 1 yr?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris M. D.
Address 1824 N. Franklin St. Date signed 9-13-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. 66831

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 749 Wilmer Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JESSIE JONES

3 (b) If veteran of some war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Ruth Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1918

8. AGE: Years	Months	Days	If less than one day
30	3	3	hr. min.

9. Birthplace Raleigh, N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Water Department

FATHER
12. Name Samuel Jones
13. Birthplace Franklin Co. Va.

MOTHER
14. Maiden Name Lucille Yarbrough
15. Birthplace Waite County, Va

16 (a) Informant Lelia Anderson
(b) Address 1305 Myrtle Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Sept. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Raleigh N.C. Richmond, Va.
Location

18 (a) Funeral director Mr Katie R. Williams
(b) Address 322 E. Lehmoden St.

19 (a) SEP 15 1948 (Date rec'd by registrar) (b) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11, 1948, at 3 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab-wound of left femoral artery.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-11-48 at A. M.
(b) Where did injury occur? 749 Wilmer Court
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Sharp Instrument

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 9-11-48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

✓ 666832 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 N. Hilton St.,
(c) Hospital or institution: 15-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 91-3-11

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 6
(d) Street No. 1711 N. Hilton St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Martina Lewis

3 (b) If veteran, name war ---
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ------
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1857

8. AGE: Years	Months	Days	If less than one day
91	3	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired School Teacher
11. Industry or business Balto. City

FATHER
12. Name Thomas Lewis
13. Birthplace Hagerstown, Md.

MOTHER
14. Maiden Name Mary M. Veara
15. Birthplace Madeira

16 (a) Informant Miss Jennie M. Lewis
(b) Address 1711 N. Hilton St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-1948 (month) (day) (year)
(c) Cemetery or crematory xx Greenmount
Location Baltimore, Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) 1948 (b) Rec'd by registrar Thurlington Williams, Registrar

MEDICAL CERTIFICATION 9.15

20. DATE OF DEATH Sept. 13, 1948, at p. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1948 to Sept 13 1948, and that I last saw her alive on Sept 13 1948.

Immediate cause of death arteriosclerotic Hypertensive Cardio vascular disease — Duration years?
Due to
Due to
Other Conditions Carcinoma of right breast — 6 month
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Sullivan M. D.
Address 291 Barrison Blvd Date signed 9-15-48

93 D

V-3 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Fusting 666833 BALTIMORE CITY HEALTH DEPARTMENT ✓ 666833
11 E Chase CERTIFICATE OF DEATH 93D Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address (949 Montpelier St.
(c) Hospital or institution: 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 949 Montpelier Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick P. Wagner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Catherine A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 6, 1866

8. AGE: Years	Months	Days	If less than one day
82	5	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retried
11. Industry or business

FATHER
12. Name Frederick Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Germany

16 (a) Informant Mrs. Jennie Herrmann
(b) Address 949 Montpelier Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305, Harford Road #14

19 (a) Date received by registrar SEP 15 1948 (b) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1948 at 6.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1947, to 9-13 1948.
and that I last saw him alive on 9-13 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Hypertensive - Arteriosclerotic	?
Due to C-V. Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature William H. Fusting M.D.
Address 11 E. Chase St. Date signed 9-14-48

X

Dr. Lilienfeld 666834 BALTIMORE CITY HEALTH DEPARTMENT ✓ 666834
714 E. Preston CERTIFICATE OF DEATH 13 1A Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1705 Holbrook Street
(c) Hospital or institution: 7-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Holbrook Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Ann Fishpaugh

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife John W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 6, 1869

8. AGE: Years 79 | Months 2 | Days 8 | If less than one day: hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John Frank
13. Birthplace Md.

MOTHER
14. Maiden Name Anna ?
15. Birthplace Md.

16 (a) Informant Mr. John W. Fishpaugh
(b) Address 1705 Holbrook Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Date received by Registrar SEP 15 1948 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1947 to Sept 14 1948, and that I last saw her alive on Sept 13 1948

Immediate cause of death: Uremia — Duration: 5 days

Due to: Cardio-Vascular renal disease

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Lilienfeld M. D.
Address 714 E. Preston Date signed Sept 15 1948

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157M

G66835
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 N. Rose Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ROLAND CROSS, Jr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1948

8. AGE: Years — | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Roland Cross, Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rita Kuzma
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)
(c) Cemetery or ~~xxxxx~~ Holy Redeemer
Location 4430 Belair Rd., Balto. Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

SEP 15 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

DEAD MEDICAL CERTIFICATION ON ARRIVAL

20. DATE OF DEATH Sept. 14 1948, at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1948, to Sept 14 1948, and that I last saw him alive on Sept 14 1948.

Immediate cause of death aspiration of food — Duration Life

Due to weakness of swallowing muscles MUSCULATUM

Due to Angiotonia Congenita ANGIOTONIA CONGENITA

Other Conditions Pectus Excavatus (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature O'Neill Sysanglety, M. D.
Address Johns Hopkins Hosp. Date signed 9-15-48

Released to HOSPITAL To Be Approved by Medical Examiner

MEDICAL EXAMINER'S CASE

666836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 F

Registered No. 666836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 S. Fremont Ave D-01 A-c
(c) Hospital or institution 22 - 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 S. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Nolan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 6, 1917.

8. AGE: Years	Months	Days	If less than one day: hr.	min
31	10	5		

9. Birthplace A. A. County, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Scott Nolan
13. Birthplace Northumberland Co. Va.

MOTHER
14. Maiden Name Agnes Allen
15. Birthplace A. A. Co. Md.

16 (a) Informant Mrs. Bertha Stewart
(b) Address 614 S. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-1948 (month) (day) (year)

(c) Cemetery or crematory
Location Jones Md.

18 (a) Funeral director Mrs. K. R. Williams
(b) Address 322 N. Richmond St. Huntingtown Calvert Co. Md.

19 (a) 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1948 at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Pulmonary T.B.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Schmidt M.D.
Medical Examiner.
Date signed 9/12/48

VS 151

Type or use ink. Physicians: please write the causes of death clearly and legibly.

666837

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94A

666837 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3802 Fordleigh Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 20
(e) Length of stay in Baltimore (yrs., mos., or days) 19 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3802 Fordleigh Road. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA M. DEAN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Max Dean.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1874.

8. AGE: Years	Months	Days	If less than one day
74	10	29	hr. min.

9. Birthplace Boston, Mass. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Solomon Meyers,
13. Birthplace Germany.

MOTHER
14. Maiden Name Augusta Prinz,
15. Birthplace Germany.

16 (a) Informant Mrs. Louise Loewenson,
(b) Address 3802 Fordleigh Road.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/16/48. (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director [illegible]
(b) Address 1902 Eutaw Place.

19 (a) [illegible] 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13th. 1948 at 11.45 M

21. I certify that death occurred on the date above stated, that I attended deceased from May 1942 to Sept 14 1948 and that I last saw her alive on Sept 13 1948.

Immediate cause of death	Duration
Acute pulmonary edema	2 hours
Due to Coronary thrombosis	6 hours
Due to	
Other Conditions Hypertension	6 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan Bernstein M. D.
Address 1109 N. Calvert St. Date signed

VS 150

666838

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94-A

666838
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 E. 31st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT ARNOLD JONES) Robert Jones

3 (b) If veteran, name war No

3 (c) Social Security Account No. 214-01-5236

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose B. (Donohue) Jones

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1894

8. AGE: Years (54) | Months 11 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Estimator

11. Industry or business Monitor Controller Co.

FATHER
12. Name Robert D. Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Belle Horney
15. Birthplace Maryland

16 (a) Informant Mrs. Rose B. Jones
(b) Address 1704 E. 31st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

(a) 9/15 1948 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/14 1948, at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. C. Lubenko M.D.
Medical Examiner.
Date signed 9/15/48

G66839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 461

G66839 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3211 Kenyon ave.
(c) Hospital or institution: 213
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Kenyon ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL JAMES MOLONEY

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary H. Moloney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 21, 1893

8. AGE: Years: 54 | Months: 10 | Days: 22 23 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Policeman (Retired)

11. Industry or business: Baltimore City

FATHER
12. Name: Michael Moloney
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Annie Carberry
15. Birthplace: Ireland

16 (a) Informant: Mrs. Mary H. Moloney
(b) Address: 3211 Kenyon ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location:

18 (a) Funeral director: Chas. J. Evans & Son Inc.
(b) Address: 118 N. Mt. Royal Ave.

19 (a) (Date received by registrar) (b) [illegible] Registrar

SEP 15 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1948 at 4 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to Sept 14 1948, and that I last saw him alive on Sept 13 1948.

Immediate cause of death: Carcinoma of Rectum — Duration

Due to:

Due to:

Other Conditions: Cirrhosis of Liver
Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation: April 1948 Carcinoma

Major findings of operation: Carcinoma Cirrhosis of Liver

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Walter A. Anderson M.D.
Address: 3001 Shannon Drive Date signed 9/14/48

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666840 Room

11 42 7837

BALTIMORE CITY HEALTH DEPARTMENT ✓ 666840

CERTIFICATE OF DEATH 131

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Bailey
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years 33 | Months | Days | If less than one day: hr. min

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Ben Harvey
13. Birthplace ?

MOTHER 14. Maiden Name Mary Lusitania
15. Birthplace ?

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 16 48 (Month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Balto. Co.

18 (a) Funeral director Elliott Daughter
(b) Address 2116 N. Caroline St.

19 (a) SEP 15 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948 at 5:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 12 1948 to 9 12 1948 and that I last saw her alive on 9-12-1948

Immediate cause of death Respiratory Collapse. Duration minutes

Due to Fibro-caseous pulmonary Tuberculosis with Cavitation months.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary Tbc. & Cavitation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Courtney J. Iggo. M. D.
Address 1 W. Mt. Royal Ave Date signed 9-13-48

To be Approved by Medical Examiner H. J. Mallin, M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

666841 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 68 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES EDWARD WHITE

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Florence White

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Jan. 13 ?

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Oriole, Md. (Town, county, and state)

10. Usual Occupation Captain

11. Industry or business Seafarer

FATHER
12. Name Mat White
13. Birthplace Oriole, Md.

MOTHER
14. Maiden Name Adelaide Holland
15. Birthplace Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 19. 1948 (month) (day) (year)
(c) Cemetery or crematory St. James. Cem.
Location Oriole. Md.

18 (a) Funeral director Elroy. C. Wilson
(b) Address 1030. Brantly. Ave.

19 (a) SEP 15 1948 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1948 at 7:50A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jul 8 1948 to Sept. 14 1948 and that I last saw him alive on Sept. 14 1948

Immediate cause of death Adeno Carcinoma of right lung with metastases to lymph nodes, thyroid, kidneys, adrenalin, liver and

Due to right humerus with pathologic fracture

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

Duration: Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature J. A. van Ackeren, Medical Director
Address Medical Officer in Charge Signed 9/14/48

VS 159

G66842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

G66842 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carolina St.
(c) Hospital or institution: St. Joseph 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1939 Fleet St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Anthony August Gruebl

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Katherine Cecilia Gruebl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-20-02

8. AGE: Years	Months	Days	If less than one day
45	10	24	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Machine Operator
11. Industry or business Cooper's Co.

FATHER
12. Name George Gruebl
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Kopp
15 Birthplace Germany

16 (a) Informant Deceased
(b) Address 1939 Fleet St., Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Tully & Zeller
(b) Address 1603 Huntington Ave, Baltimore, Md

19 (a) SEP 15 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1948 at 7:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1948 to Sept 14 1948. and that I last saw h[illegible] alive on Sept 14 1948.

Immediate cause of death Overwhelming Infection.

Due to Agranulocytosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of autopsy: Coma of ischopurulent Lymph Nodes, Spleen & Liver

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, industrial place, etc.)
(e) Means of injury

23. Signature John M. Rehkopf M. D.
Address St. Joseph Hospital Date signed 9-14-48

VS 150

76a

48-13313
G66843

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 180

G66843 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If so, name country

3 (a) FULL NAME Lyons Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1948

8. AGE: Years 2 (22 M) | Months | Days 21 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Roberts Harris
13. Birthplace Balto., Md.

MOTHER 14. Maiden Name Lee Gales
15. Birthplace Virginia

16 (a) Informant: Robert Harris
(b) Address 1848 Pennsylvania Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Pk
Location Balto County, Md.

18 (a) Funeral director Charles H. Gorter
(b) Address 2112 Connecticut Ave

19 (a) SEP 15 1948 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Sept 1948 at 10:16 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions 2nd & 3rd degree Burns surface & extremities
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12 Sept 48 at 1 A. M.
(b) Where did injury occur? 928 N. Fulton Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Fire at home - thrown from window

23. Signature Earl L. Rough M.D.
Medical Examiner
Date signed 12 Sept 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66844 GC-C 78153 — 66844 GRV 180 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 16-H
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N. Fulton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virginia Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1946

8. AGE: Years	Months	Days	If less than one day
2	4	23	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER	12. Name	Alvin Harris
	13. Birthplace	Balto., Md
MOTHER	14. Maiden Name	Annie Enght
	15. Birthplace	North Carolina

16 (a) Informant Robert Harris
(b) Address 1841 Pennsylvania Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Balto County Md.

18 (a) Funeral director Chas H. Corpus
(b) Address 512 Carrollton Ave.

19 (a) (Remington-Holliswood, Md.)
(Date received by registrar) SEP 15 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948 at 3:30 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 2nd° and 3rd° Burns Entire Body Surface

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-12-48 at 1 A.M.
(b) Where did injury occur? 928 N Fulton Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Conflagration at home

23. Signature Robert B. McFadden M.D. Medical Examiner.
Date signed 9-12-48

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66685

66685 BC-8-85822

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alvin Harris Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-30-44

8. AGE: Years: 4 | Months: 1 | Days: 13 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alvin Harris
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie Knight
15. Birthplace North Carolina

16 (a) Informant Robert F. Harris
(b) Address 1848 Pennsylvania Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Balto County, Md

18 (a) Funeral director Chas. H. Carter
(b) Address 512 Carrollton Ave.

19 (a) SEP 15 1948 (b) Registrar Huntington Hollins, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948, at 3:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 2° and 3° Burns of the entire body surface.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-12-48 at 1 A.M.
(b) Where did injury occur? 928 Fulton Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Conflagration at home

23. Signature Robert B. McAdoo M.D. Medical Examiner.
Date signed 9-12-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G666846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No. G666846

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1644
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 20 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N. Fulton Avenue
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME ELSIE HARRIS

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert F. Harris

6 (c) If alive, give age: 3 years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1910

8. AGE: Years: 38 (D) M | Months: 8 | Days: 12 | If less than one day: ..... hr. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business .....

MOTHER | FATHER

12. Name: Samuel Bell

13. Birthplace: Virginia

14. Maiden Name: Rosa Brandon

15. Birthplace: Virginia

16 (a) Informant: Robert Harris

(b) Address: 1848 Pennsylvania Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)

(c) Cemetery or crematory: Arbutus Mem'l. Pk.
Location: Balto County. Md

18 (a) Funeral director: Charles E. Cooper

(b) Address: 512 N. Carrollton Ave

SEP 15 1948 (Date rec'd by registrar) Washington Boulevard

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 12, 1948 at 10:55 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to HER death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Extensive burns

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-12-48 at ~~Approx. 10~~ A. M.

(b) Where did injury occur? 928 N Fulton Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? Home (While at work?) No

(d) Means of injury Conflagration

23. Signature George G. Merrill M.D.
Examiner.

Date signed 9-13-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G66847 / 016 ✓ G666847

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 180

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Alvin Harris Sr.

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1926

8. AGE: Years	Months	Days	If less than one day
22	6	20	hr. ..... min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business Self

FATHER
12. Name Robert Harris
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Edie Tribbs
15. Birthplace Virginia

16 (a) Informant Robert Harris
(b) Address 1849 Pennsylvania Ave.

17 (a) Burial (b) Date thereof 9/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location Baltimore County, Md.

18 (a) Funeral director Chas H. Gorter
(b) Address 512 Carrollton Ave

19 (a) ..... (b) ..... Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1948 at 2:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 2° and 3° Burns of the entire body surface

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-12-48 at 1 A M.
(b) Where did injury occur? 928 N. Fulton Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Conflagration at home

23. Signature Robert B. McAdden M.D.
Medical Examiner.
Date signed 9-12-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Harbold G66848 BALTIMORE CITY HEALTH DEPARTMENT G66848
4706 Harford CERTIFICATE OF DEATH 443 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6113 Sefton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6113 Sefton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Elizabeth Shipman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife William M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 26, 1904

8. AGE: Years	Months	Days	If less than one day
43	8	18	hr. min.

9. Birthplace Phillipsburg, N.J. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name Frederick Mamber
13. Birthplace Germany

MOTHER 14. Maiden Name Fredericka Rau
15. Birthplace Germany

16 (a) Informant Mr. William M. Shipman
(b) Address 6113 Sefton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-48 (month) (day) (year)
(c) Cemetery or crematory St. James Luth Cem.
Location Phillipsburg, New Jersey

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

SEP 15 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1948 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1948 to Sept 13 1948.
and that I last saw her alive on Sept 13 1948.

Immediate cause of death Hodgkins Disease — Duration 4 years
Due to
Due to
Other Conditions Pulmonary edema Abdominal lymphadenopathy
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold M.D.
Address 4706 Harford Rd Date signed 9/15/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Harbold 666849 BALTIMORE CITY HEALTH DEPARTMENT ✓ 666849 Registered No.

CERTIFICATE OF DEATH 46 E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2816 Reuckert Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 Reuckert Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna J. Poehlman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Frederick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 9, 1882

8. AGE: Years	Months	Days	If less than one day
66	2	5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name William Mayers
13. Birthplace Md.

MOTHER 14. Maiden Name Minnie Schmidt
15. Birthplace Md.

16 (a) Informant Mr. Edmund Poehlman
(b) Address 2816 Reuckert Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-48 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1948 at 2 P M

21. I certify that death occurred on the date above stated, that I attended deceased from March 23 1945 to Sept 14 1948 and that I last saw her alive on Sept 11 1948

Immediate cause of death Carcinoma of Caecum c metastasis — Duration 1 1/2 years

Due to

Due to

Other Conditions Pulmonary tuberculosis 20 yrs
Chronic myocarditis
Chronic interstitial nephritis

(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature H. V. Harbold M.D. M. D.
Address 4706 Harford Road Sign 9/15/48

VS 150

Please write especially important. Physicians: please write the causes of death clearly and legibly.

666850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 666850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 311 S. Fremont Ave
(c) Hospital or institution: 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 S. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Joseph G. Roberts (Rutkosheosky)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 97

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Sailor
11. Industry or business

FATHER
12. Name Joseph Roberts
13. Birthplace Lith.

MOTHER
14. Maiden Name Tekla Zukauskas
15. Birthplace Lith.

16 (a) Informant Joseph Boptill
(b) Address 626 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16 - 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Baltimore Md.

18 (a) Funeral director Joseph Kasmauskas
(b) Address 602 Washington Blvd Bal

19 SEP 16 1948 (b) Baltimore Md (Registrar)
(Filled in by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1948 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7 1948 to 9-13 1948 and that I last saw him alive on 9-13 1948

Immediate cause of death	Duration
Myocardial degeneration Chronic myocarditis	1 year
Due to Coronary Artery Disease	2 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich Jr. M. D.
Address 1227 Eutaw Bldg Date signed 9-14-48

VS 150

66851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66851 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4230 Park Heights Ave
(c) Hospital or institution:

15-13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4230 Park Heights Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE RUDMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 71 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Home Work

11. Industry or business

FATHER 12. Name Benjamin Segelman

13. Birthplace Russia

MOTHER 14. Maiden Name Rachael

15. Birthplace Russia.

16 (a) Informant Minnie Gordon

(b) Address 4230 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-48 (month)

(c) Cemetery or crematory Bnai Israel

Location Southern Ave

18 (a) Funeral director Jack Levin Inc

(b) Address 2108 Eastern Place

19 (a) SEP 16 1948 (b) Huntingtown Hillsboro, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15/48 19 . at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within three months of death).

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, in industrial plant, in public place? While at work?

(d) Means of injury

23. Signature John R Dorsey M.D.
Medical Examiner.

Date signed 9/15/48

666852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 666852

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address No. 413 Park Heights Ave
(c) Hospital or institution: Mt Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachael Myers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11 7 3

8. AGE: Years 75 Months Days If less than one day hr. min.

9. Birthplace Pittsburgh Pa (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not known
13. Birthplace Poland

MOTHER
14. Maiden Name Betty Polaus
15. Birthplace

16 (a) Informant Mrs H F Wolfram
(b) Address 4502 Manor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-48 (month) (day) (year)
(c) Cemetery or crematory
Location Norfolk, Va

18 (a) Funeral director Mt Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) SEP 16 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 50

20. DATE OF DEATH 9-15-48 at 2 P M

21. I certify that death occurred on the date above stated, that I attended deceased from July 20. 48 to Sep 15 48, and that I last saw h[illegible] alive on Sep 15 48

Immediate cause of death	Duration
Due to Bronchial asthma Chron. Myocarditis	2 yrs
Due to	
Other Conditions Edema Lung	2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm H Taylor M.D.
Address 2140 Eutaw Date signed 9/16/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127 A

66853 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4907 YORK RD.
(c) Hospital or institution:

27-10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 YR.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4907 YORK RD. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELEANOR JERMIMAH SLADE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife JOHN E. SLADE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 20, 1858

8. AGE: Years 90 | Months 5 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace PENNSYLVANIA (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name ASBURY R. REILEY
13. Birthplace PENNSYLVANIA

MOTHER 14. Maiden Name JULIAN LOWE
15. Birthplace PENNSYLVANIA

16 (a) Informant A. R. SLADE
(b) Address 4907 YORK RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 16 48 (month) (day) (year)
(c) Cemetery ~~crematory~~ MORELAND MEMORIAL
Location BALTIMORE

18 (a) Funeral director HENRY W. JENKINS & SONS
(b) Address YORK RD. & ROSSITER AVE.

19 (a) SEP 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1948 at 10.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1948 to Sept. 13 1948 and that I last saw h e alive on Sept. 13 1948

Immediate cause of death: Myocardial Insufficiency — Duration ...
Due to: Cholecystatis — Duration 3 days
Due to: ... — Duration ...
Other Conditions ...
(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operation: ...
of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl H. Bauman
Address 5111 York Rd Date signed 9/14/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6668:54

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83D

Registered No. 6668:54

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1922 N. Market St.
(c) Hospital or institution: N. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 N. Market St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Olivia Madden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 25, 1913

8. AGE: Years 35 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)

10. Usual Occupation Laundry worker

11. Industry or business

FATHER 12. Name Albert Madden

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Myrtle Loveday

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Bessie Harris

(b) Address 2004 Kelly Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland

(b) Address 1631 Druid Hill Ave.

19 SEP 16 1948 (Date rec'd by Registrar) (By) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1948 at 7a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1948 to Sept 14 1948 and that I last saw her alive on Sept 14 1948

Immediate cause of death: Uremia

Due to: Hypertension

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 2 weeks; 1 year

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Walsh M. D.

Address Date signed 9-16-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

66855 Registered No.

45-5-772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17-E
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Jack Henry Hobbs
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mabel Hobbs
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 12-24-18

8. AGE: Years 29 | Months 8 | Days 14 | If less than one day: hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name John Hobbs
13. Birthplace N. C.

MOTHER 14. Maiden Name Martha Brantley
15 Birthplace N. C.

16 (a) Informant:
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore

18 (a) Funeral director Wm. D. Jackson
(b) Address 1816 Penna Ave

19 (a) SEP 16 1948 (Date rec'd by registrar) Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1948 at 2 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3- 1948 to 9-12- 1948 and that I last saw him alive on 9-12- 1948.

Immediate cause of death: Tuberculous meningitis — Duration

Due to

Due to

Other Conditions
(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William D. Winternitz
Address Johns Hopkins Hospital Signed 9-15-48 M D

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66856 JL - 122690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66856

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ hr.
(e) Length of stay in Baltimore (yrs., mos., or days) ½ hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 Avon Beach Rd. -22
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Robinson-"A" - Pearl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1948

8. AGE: Years	Months	Days	If less than one day
			hr. 30 min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Robinson
13. Birthplace ?

MOTHER
14. Maiden Name Pearl ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9-9-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) SEP 16 1948 (Date rec'd by registrar) (b) Huntington Nellegues M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1948 at 10.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3, 1948 to Sept. 3 1948, and that I last saw her alive on Sept. 3 1948

Immediate cause of death Prematurity — Duration 2 hrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William A. Kean M. D.
Address Baltimore City Hosp. Date signed 9-9-48

VS 150

Correct age is especially important; physicians please write the causes of death clearly and legibly.

666857

JL - 122691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 666857

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 Min.

(e) Length of stay in Baltimore (yrs., mos., or days) 55 Min.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Balt.

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 124 Avon Beach Rd. -22
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Robinson "B" - Pearl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 3, 1948

8. AGE: Years	Months	Days	If less than one day
			hr. 55 min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Henry Robinson

13. Birthplace ?

MOTHER

14. Maiden Name Pearl ?

15. Birthplace ?

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9am 9-9-48 (month) (day) (year)

(c) Cemetery or crematory Baltimore City Hospitals

Location 4940 Eastern Ave.

18 (a) Funeral director

(b) Address

19 (a) SEP 16 1948 (Date rec'd by registrar) Huntington Williams, M.D. Address Baltimore City Hospitals Date signed 9-9-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1948 at 10.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1948 to Sept. 3 1948. and that I last saw her alive on Sept. 3 1948.

Immediate cause of death [illegible]

Duration 55 min.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death.)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William P. Kean M. D.

Hospital Dispostal (4-19-53)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1-9

Registered No. 666858

666858 L.C. A65366

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 911 Jeffrey St (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Baby girl Charlillo

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) .....

8. AGE: Years	Months	Days	If less than one day
		1	32 hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER 12. Name John Anthony Charlillo

13. Birthplace Ohio

MOTHER 14. Maiden Name Annicchiarico DaMarco

15 Birthplace N.Y.

16 (a) Informant .....

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)

(c) Cemetery or crematory Cripple

Location .....

18 (a) Funeral director .....

(b) Address .....

19 (a) SEP 16 1948 (Date rec'd by registrar) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 11 - 1948 at 12 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9- 1948 to 9-11- 1948.

and that I last saw her alive on 9-11- 1948.

Immediate cause of death atelectasis and CNS damage — Duration .....

Due to Prematurity

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence 9-11-48 at 12 15 A M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature John T. Ryan M. D.

Address Johns Hopkins Hosp. Date signed 9-11-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G668:59

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186 A

Registered No. G668:59

G668:59

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood and Greene

(c) Hospital or institution: University Hospital J-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3618 Edmor Rd. (18) (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Albert E. Smith.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife LENA C. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12th 1870

8. AGE: Years 78 Months 2 Days 2 If less than one day hr. min.

9. Birthplace Missouri (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Albert smith

13. Birthplace California

MOTHER 14. Maiden Name Liza Butler

15. Birthplace Missouri

16 (a) Informant pt himself.

(b) Address

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 9/17/48 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Woodlawn

Location md.

18 (a) Funeral director William Cook Inc

(b) Address 217 St. Paul St

19 (Date rec'd by Registrar) SEP 16 1948 Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1948 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1948 to 9/14 1948.

and that I last saw him alive on 9/14 1948.

Immediate cause of death	Duration
Resp Cased.	
Due to Hypostatic pneumonia	1 day.
Due to Fracture, femoral neck, rt 4 days fracture, 9th rib, rt.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence 9/10/48 at M

(c) Where did injury occur? Balto (City or town) Balto (County) md. (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Bathroom of home (Specify type of place) While at work? no

(e) Means of injury fall- ~~slipped~~ fell to floor

23. Signature J R Davidow M. D.

Address Univ Hosp Balto, md

Date signed 9/14/48

Certified by J. Maloney M.D.

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly!

666860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164 C

Registered No. 666860

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-R
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Cathedral St., Milner Hotel (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALBERT (TOSIER) TOZER

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age [illegible] years

7. Birth date of deceased (mo., day, yr.) About 1873

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant BEATRICE MONDORFF
(b) Address 1604 PARK AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/48 (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 16 1948 (Date rec'd by Registrar) Washington Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 1948, at 5 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet-wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-9-43 at P M?
(b) Where did injury occur? Milner Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? hotel While at work? no
(d) Means of injury Firearms

23. Signature George W. Merrill M.D. (Medical Examiner)
Date signed 9/10/48

VS 151

666861

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 137A

666861
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A. Co.
(c) City or town Severna Pk
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Watts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	

6 (b) Name of husband or wife Minta
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 11-20-76

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71	9	25		

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Marion Benjamin Watts
13. Birthplace Md

MOTHER
14. Maiden Name Letcher Marion Coleman
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 19 1948 (month) (day) (year)
(c) Cemetery or crematory Jones Station
Location Jones Sta. Md.

18 (a) Funeral director J. B. Johnson
(b) Address Box 462 Annapolis, Md.

19 (a) SEP 16 1946 (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1948, at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/8 1948 to 9/15 1948, and that I last saw h[illegible] alive on 9/15 1948.

Immediate cause of death	Duration
Cardiac failure + pulm. edema	6 hrs.
Due to Arteriosclerotic cardiovascular disease	10 yrs.
Due to	
Other Conditions Benign prostatic hypertrophy + recto urethral fistula	5 yrs.

(Include pregnancy within 3 months of death)
Date of operation 8-24
Major findings of operation: Benign prost. hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify (b), (c), or (d) place)
(e) Means of injury

23. Signature W R Boothin
Address The Johns Hopkins Hospital Date signed 15 Sept '48

93D

VS 130

66862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. 66862

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Druid St

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days

(e) Length of stay in Baltimore (yrs., mos., or days) 66 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1419 Druid St (Rural give location)

(e) Citizen of foreign country ... (Yes or No)

If yes, name country

3 (a) FULL NAME David Bowles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 20 1883

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Richmond Va (Town, county, and state)

10. Usual Occupation Mason

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 15 1948

18 (a) Funeral director Bureau of Health

(b) Address

19 (a) SEP 16 1948 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27/ 19 48 at 11 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17 19 48 to 8/27 19 48; and that I last saw h alive on 8/27 19 48

Immediate cause of death Uremia

Due to Hypertension 10 Y

Due to Cancer

Other Conditions Prostatic Hypertrophy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Extend. of Uremia, Edema & Congest.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature

Address Date signed 9/2/48

VS 150

Myers

666863 BALTIMORE CITY HEALTH DEPARTMENT 666863

CERTIFICATE OF DEATH

93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 527 York Rd. Towson
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 York Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bessie Mae Myers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	—

6 (b) Name of husband or wife William Henry Myers, Sr.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1878

8. AGE: Years	Months	Days	If less than one day
69	8	29	— hr. — min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER 12. Name George Block

13. Birthplace Maryland

MOTHER 14. Maiden Name Rebecca Parks

15. Birthplace Maryland

16 (a) Informant Mrs. Margaret DeMoss

(b) Address 527 York Rd, Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17, 1948 (Month) (day) (Year)

(c) Cemetery or crematory Mays Chapel Cem.

Location Timonium, Balto. Co., Md.

18 (a) Funeral director John Burns' Sons

(b) Address Towson, Md.

19 (a) SEP 16 1948 (b) Huntington-Williamsport, Md.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-14 1948 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1948 to 9-14 1948, and that I last saw her alive on 9-7 1948

Immediate cause of death	Duration
Pulmonary Edema	2 hr
Due to Heart Failure	2 days
Due to Coronary occlusion	5 yrs
Due to A.S.C.V.D.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation: 0

of autopsy: 0

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature. John R. Smith, M.D.

Address Union Mem. Hosp Date signed 9/14/48

VS 150

G66864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95C ✓

Registered No. G66864

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 Whatcoat St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Booth

3 (b) If veteran, name war W.W.I

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1895

8. AGE: Years 53 | Months 4 | Days 28 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant: Mary Booth
(b) Address 830 Whatcoat St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-48 (month)
(c) Cemetery or crematory Baltimore National
Location Baltimore, Md.

18 (a) Funeral director Geo. H. Nelson
(b) Address 130 [illegible]

SEP 16 1948 (Date filed by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15, 1948, at 4 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hypertrophy of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Earl L. Royer M.D.
Medical Examiner

Date signed 9-15-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

666865 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 W North Ave.
(c) Hospital or institution: 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 W North ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Lewis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Hyland Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1882

8. AGE: Years	Months	Days	If less than one day: hr	min.
66	5	29		

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Moses Hawkins
13. Birthplace Virginia

MOTHER
14. Maiden Name Nettie (unknown)
15. Birthplace Virginia

16 (a) Informant Rev. B. F. Jackson
(b) Address 1620 W North ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (month) (day) (year)
(c) Cemetery or crematory Phila
Location Phila Pa

18 (a) Funeral director Lee-Ho-Kelly
(b) Address 1303 Pennsylvania Ave Huntingdon Williamsport, Pa

19 (a) (Signature of local registrar) Registrar

SEP 16 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1948, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1948, to Sept 17 1948, and that I last saw h[illegible] alive on Sept 16 1948.

Immediate cause of death Bronchopneumonia — Duration 8 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 517 N. Schroeder Date signed 9/15/48.

66886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 66886

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 Ingleside Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellingham T. Walgrove

3 (b) If veteran, name war No

3 (c) Social Security Account No. -

4. Sex M | 5. Color or race W | 6 (a) Single, ~~married, widowed, or~~ divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) AUG. 23, 1886

8. AGE: Years 62 | Months 0 | Days 22 | If less than one day hr. min.

9. Birthplace New York, City (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business —

FATHER 12. Name George Walgrove
13. Birthplace New York City

MOTHER 14. Maiden Name M. Catherine Douglas
15. Birthplace New York City

16 (a) Informant Hospital Record
(b) Address above.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 16, '48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Greenwood
Location Brooklyn, New York

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md. Huntington, West Virginia

19 (a) SEP 16 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15 1948, at 12:39 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 9/16/48

VS 151

666867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 666867 Registered No. 930

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution: Hillcrest Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDITH E. BILL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 18, 1864

8. AGE: Years	Months	Days	If less than one day
84	0	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George Bill
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth D'Alloe
15. Birthplace England

16 (a) Informant Dr. Edith E. Bill, niece
(b) Address 3301 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1948 at 11.00 P M.

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 1947 to Sept 14 1948. and that I last saw h PR alive on Sept 14 1948

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to acute Coronary occlusion

Due to arteriosclerotic heart disease, chronic myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wentland Edmund Day M. D.
Address 4 E. 33rd St - 18 Date signed 9/14/48

VS 150

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

666868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

666868 Registered No.

5 1

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3701 Clifton Ave.
(c) Hospital or institution:

15-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDGAR W. COOK

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Judith D. Cook

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1886

8. AGE: Years: 62 | Months: 1 | Days: 1 | If less than one day: hr. min.

9. Birthplace: Atlanta, Ga.
(Town, county, and state)

10. Usual Occupation: Field Engineer

11. Industry or business: Fire Insurance

FATHER
12. Name: Lewis Cook
13. Birthplace: Milledgeville, Ga.

MOTHER
14. Maiden Name: Sarah Caroline Caldwell
15. Birthplace: Lafayette, Ga.

16 (a) Informant: Mrs. Judith D. Cook
(b) Address: 3701 Clifton Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/17/48 (month) (day) (year)
(c) Cemetery or crematory
Location: Rutherford, N. J.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 15 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1948 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/26/ 1948 to 9/14/ 1948, and that I last saw him alive on Sept. 13 1948.

Immediate cause of death: cardiac failure — Duration: 2 mo.

Due to: carcinoma of prostrate gland — 2 yrs.

Due to:

Other Conditions: cerebrial arterio-sclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edgar W. Cook M. D.
Address 3030 Edmondson Avenue Date signed 9/15/48

VS 150

666869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

666869 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Street 12
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Okenshaw Place (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Louis Schreitz

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Helen A. Schreitz
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr) June 2, 1878

8. AGE: Years	Months	Days	If less than one day
70	3	12	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Broker
11. Industry or business

FATHER
12. Name John A. Schreitz
13. Birthplace Maryland

MOTHER
14. Maiden Name Katherine A. Shannon
15. Birthplace Maryland

16 (a) Informant Patient Wm. Louis Schreitz
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 16 1948 (Date received by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1948, at 4 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1948 to 9-14 1948, and that I last saw h, M alive on 9-14 1948.

Immediate cause of death Acute Coronary Occlusion — Duration 24 hrs.

Due to Coronary Artery Disease — 2 yrs.

Due to

Other Conditions Prostatic Hypertrophy, Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Smith, Jr. M.D.
Address Union Mem. Hosp. Date signed 9/14/48

VS 150

666870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 666870

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 r Welcome alley
(c) Hospital or institution: 22-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 r Welcome al
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Rawlings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Widow

6 (b) Name of husband or wife William Rawlings
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-11-1896

8. AGE: Years	Months	Days	If less than one day
52	6	2	hr. min.

9. Birthplace Oxford Delaware
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name William Thompson
13. Birthplace Oxford Delaware

MOTHER
14. Maiden Name Catherine
15. Birthplace Oxford Del-

16 (a) Informant Hattie Johnson
(b) Address 5-8 E Oxford

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) SEP 16 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1948 at 5a M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/23 1948 to 9/13 1948, and that I last saw h alive on 9/1 1948.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Hypertension	
Due to Chronic Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr Dr Saunders M.D.
Address 11 r Welcome Date signed 9/14/48

VS 150

66871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 66871

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied/ correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 N. Bruce Street
(c) Hospital or institution: 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N. Bruce ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Florence Peck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 22, 1899

8. AGE: Years	Months	Days	If less than one day hr.	min.
48	9	22		

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Household

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Mary Brown
15. Birthplace ?

16 (a) Informant Phyllis Everett
(b) Address 22 N. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St.

19 (a) SEP 16 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14, 1948, at 9:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11, 1948, to Sept. 14, 1948, and that I last saw her alive on Sept. 13, 1948.

Immediate cause of death	Duration
CARDIAC FAILure	Day
Due to Acute Pulmonary Congestion	2 Days
Due to Lobar Pneumonia	2 Days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 W. Franklin St. Date signed 9-15-48

V8 150

666872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666872

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital 15-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Overview Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Simon Molofsky

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-6635

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Annie Molofsky
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Salesman - Retired
11. Industry or business Tailor

FATHER
12. Name Leon Molofsky
13. Birthplace Russia

MOTHER
14. Maiden Name Ida Gelbau
15. Birthplace Russia

16 (a) Informant Mr. Leonard Molofsky
(b) Address 3701 Overview Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-48 (month) (day) (year)
(c) Cemetery or crematory Shaarei Zion Cong.
Location Rosedale

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1124-26 W. North Avenue

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 16 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1948, at 3:20 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10:20 P.M 9/15 1948 to 3:20 AM 9/16 1948. and that I last saw h[illegible] alive on 9/16 1948.

Immediate cause of death Cerebral vascular ~~accident~~ embolism
Due to R heumatic heart disease
Due to (auricular fibrillation)
Due to Cardiac insufficiency (Cardiac enlargement)
Other Conditions Subacute bacterial endocarditis, mitral
(Include pregnancy within 3 months of death)

Duration: 12 hrs; unknown; 5 mos

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin D. Davis
Address W. Balto. Gen. Hosp. Date signed 9-16-48 M. D.

PLEASE WRITE PLAINLY, with ink. Every question must be answered. Information should be correctly supplied. Physicians: please write the causes of death clearly and legibly. Special care is especially important.

666873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 666873

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 213 Light St.

(c) Hospital or institution: So. Balto. Gen. Hosp. 21-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1271 Washington Blvd (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Henry L. Letcher

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Harriett E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15th 1883

8. AGE: Years	Months	Days	If less than one day: hr.	min.
64	11	1		

9. Birthplace Massachusetts (Town, county and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER 12. Name Henry L. Letcher

13. Birthplace Canada

MOTHER 14. Maiden Name Unknown

15. Birthplace Massachusetts

16 (a) Informant Mrs Harriett E. Letcher

(b) Address 1271 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem.

Location 2930 Frederick Ave

18 (a) Funeral director John J. Cowan & Son

(b) Address 904-03 W. Pratt St.

19 (a) SEP 16 1948 (Date received by Registrar) (b) Huntington Wellman Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1948, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-17, 1948, to 9-16 1948, and that I last saw h[im] alive on 9-16 1948.

Immediate cause of death: Cardiac failure

Due to Myocardial infarction

Due to Coronary occlusion

Other Conditions Mesenteric thrombosis, Aortic aneurysm, Gallstones

(Include pregnancy within 3 months of death)

Date of operation 6-17-48 + 9-11-48

Major findings of operation: Cancer of left lung, Myocardial infarction, Aortic aneurysm

of autopsy: Mesenteric thrombosis

Duration
36 hr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Mary C. Letcher M.D.

Address 213 Light St. Date signed 9-17-48

G66874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G66874

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 S. Kenwood Ave.
(c) Hospital or institution: 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 S. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma P. Nagler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George W. Nagler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 22, 1878

8. AGE: Years	Months	Days	If less than one day
70	6	24	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Bernard Hasse
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Musch
15. Birthplace Germany

16 (a) Informant Husband
(b) Address 604 S. Kenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory Schwartz's
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) SEP 16 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1948, at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Sept 1948, and that I last saw h[illegible] alive on Sept 15 1948.

Immediate cause of death
Coronary Occlusion — Duration 2 hrs.
Due to arteriosclerosis — 5 yrs.
Due to
Other Conditions Diabetes Mellitus; Colelithiasis; Duodenal Ulcer (Include pregnancy within 3 months of death)

Date of operation DIVERTICULUM OF
Major findings of operation: DUODENUM
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeGoullon M.D.
Address 601 S. Ellwood Ave. Date signed 9/16/48

942

VS 150

Office use is especially important. Physicians: please write the causes of death clearly and legibly.

G66875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. G66875

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 854 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VINCENT VINCENTI

3 (b) If veteran, name war ———

3 (c) Social Security Account No. 219-07-3133

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife ———

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1899

8. AGE: Years	Months	Days	If less than one day
(Amt) 48	10	29	hr. min.

9. Birthplace San. Clementi, Italy (Town, county, and state)

10. Usual Occupation Garage Man

11. Industry or business American Brewery Garage

FATHER
12. Name Ferdinado Vivenzio
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Varone
15. Birthplace Italy

16 (a) Informant Reuben L. Uman (Lawyer)
(b) Address 110 E. Lexington St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9-17-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. & Moravia Ave.

18 (a) Funeral director Frank Della Noce
(b) Address SEP 16 1948 S. High Street

19 (a) (Date rec'd by registrar) **(b)** Burial Permit Issued

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15, 1948 1:35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull c Intra-Cranial Hemorrhage

Due to

Other Conditions Cirrhosis of Liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/14/48 at 12-30 A. M.
(b) Where did injury occur? In front of 1035 E. Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by fist

23. Signature Edward L. Kruger M.D.
Medical Examiner
Date signed 15 Sept 48

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66876

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 931

Registered No. 66876

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 Gorsuch Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Gorsuch
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John N. Becker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1857

8. AGE: Years	Months	Days	If less than one day
91	6	13	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Samuel Becker
13. Birthplace Penna

MOTHER
14. Maiden Name Mary Jane McDermott
15 Birthplace Penna.

16 (a) Informant Mrs Myrtle Zeller
(b) Address 519 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John G. Moran
(b) Address 3000 E. Balt. St.

19 (a) SEP 16 1948 (Date rec'd by Registrar) (b) Funeral to be held in Mass. Meeting House
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1948, at 3.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 2 1948, to SEPT. 15 1948, and that I last saw him alive on SEPT. 14, 1948.

Immediate cause of death	Duration
Myocardial failure	1 day
Due to Chronic Myocarditis	2 yrs
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Saylor M. D.
Address 3902 Greenmount Ave Date signed Sept. 15, 48

VS 150

6877 JL - 118456

CERTIFICATE CORRECTED 9-1-56

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 666877

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Street Address
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Hanson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1887

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Brinkley
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Gashur
15. Birthplace Portugal

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Glen Arm Rd

18 (a) Funeral director Stakem Bros
(b) Address 1301 Eastern Ave

19 (a) Date rec'd by local registrar SEP 17 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5, 1948, at 7 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 1948 to Sept. 5 1948, and that I last saw her alive on Sept. 5 1948.

Immediate cause of death	Duration
Bronchogenic Carcinoma Rt upper lobe.	3 mos.
Due to	
Due to	
Other Conditions Generalized extension. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A Nelson Jr. M. D.
Address Balto City Hosp Date signed Sept 48.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66878

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 72 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County Long Island
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 89 Jason Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES JOSEPH DEVLIN

3 (b) If veteran, name war -

3 (c) Social Security Account No. 078-14-4399

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1897

8. AGE: Years 51 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace NY (Town, county, and state)

10. Usual Occupation Oiler

11. Industry or business Seafarer

FATHER
12. Name James J. Devlin
13. Birthplace NY

MOTHER
14. Maiden Name Nellie Dwyer
15. Birthplace NY

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20-48 (month) (day) (year)
(c) Cemetery or crematory New York City
Location New York
18 (a) Funeral director Edgeworth Funeral Chapel
(b) Address 3911 Liberty Heights Ave.

19 SEP 17 1948 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1948, at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1948 to Sept. 15 1948 and that I last saw him alive on Sept. 15 1948

Immediate cause of death 1- Postoperative state, excision duodenal diverticulum — Duration
Due to 2- Peritonitis, general
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 9/13/48
Major findings of operation: Diverticulum of duodenum
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elton Moffett Jr.
Address US Marine Hospital Date signed 9/16/48

VS 199

66879

BC 48-19684

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157M

Registered No. 66879

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 243 N. Payson St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mc Kinney

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 48

8. AGE: Years	Months	Days	If less than one day
—	—	—	hr. 20 min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas J. Mc Kinney
13. Birthplace Ireland

MOTHER
14. Maiden Name Mc Donnell
15. Birthplace Balto Md

16 (a) Informant Thomas J. Mc Kinney
(b) Address 243 N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17 48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Frederick Ave

18 (a) Funeral director Thomas J. Kenny Inc.
(b) Address Hollins & Fulton Sts.

SEP 17 1948 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1948, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1948, to Sept. 15 1948, and that I last saw h[illegible] alive on Sept. 15 1948.

Immediate cause of death	Duration
Heart Failure	
Due to Anomalous blood vessels	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Imahler M. D.
Address Bon Secours Hosp Date signed 9/15/48

X

66880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 66660

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Cambridge Apartments (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME (RANDIE) WILLIAM R. HUBNER

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-09-9172

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	

6 (b) Name of husband or wife Louise Schermer

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) July 29, ~~1870~~ 1878

8. AGE: Years	Months	Days	If less than one day
70	1	18	— hr. — min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Hubner
13. Birthplace Germany

MOTHER
14. Maiden Name ~~Martin~~ Hubner Mary Harkin
15. Birthplace Baltimore, Md

16 (a) Informant (Son) John R. Hubner
(b) Address Cambridge Apt., Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18, 1948 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Henry W. Jenkins & Sons Co.
(b) Address 4905 York Road

19 (a) SEP 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1948, at 7 40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1948 to Sept. 16 1948, and that I last saw him alive on Sept. 16 1948.

Immediate cause of death — **Duration**

Lymphosarcoma (generalized) — 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard R. Bennett

Address 33rd & Calvert Union Memorial Hospital

Date signed 9/16/48 M. D.

VS 150

666881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

Registered No. 666881

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1894

8. AGE: Years	Months	Days	If less than one day
54	mnt	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Morgey
13. Birthplace Maryland

MOTHER
14. Maiden Name Josephine Barnes
15. Birthplace Maryland

16 (a) Informant Violet Holt
(b) Address 2402 Woodbrook Ave Walbrook

17 (a) Burial (b) Date thereof Sept 20/48
(Burial, cremation, or removal)
(c) Cemetery or crematory New Cathedral Cemetery
Location Old Frederick Road

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

SEP 17 1948 Hamilton Williams, M.D.
(Date received by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16, 1948 at 2.15pM

21. I certify that I took charge of the remains described above, held an Inquiry & Insnec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arterio-Sclerotic C.V.
Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
(Medical Examiner)
Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

66688

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MERCY HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43
(e) Length of stay in Baltimore (yrs., mos., or days) 16 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 4204 LOCKRAVEN BLVD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME LOUIS A. STADLER

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 065-07-2889

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: MAY R. Stadler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 20, 1876

8. AGE: Years 72 | Months 3 | Days 26 | If less than one day: hr. min.

9. Birthplace MONTANA (Helena) (Town, county, and state)

10. Usual Occupation RETIRED Mining Engineer

11. Industry or business

FATHER 12. Name LOUIS STADLER
13. Birthplace Germany

MOTHER 14. Maiden Name MARY BOHLER
15. Birthplace MO.

16 (a) Informant WIFE
(b) Address SAME

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Sep 1948, at 7:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Sep 1948 to 16 Sep 1948, and that I last saw him alive on 16 Sep 1948.

Immediate cause of death: CARCINOMA OF PROSTATE GLAND — Duration: 3 YRS
Due to
Due to
Other Conditions UREMIA — 6 WEEKS
TERMINAL PNEUMONIA 5 DAYS
(Include pregnancy within 3 months of death)

Date of operation 7 Aug 48
Major findings of operation: CARCINOMA OF PROSTATE GLAND
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Ferris M.D.
Address Mercy Hosp. Date signed 16 Sep 48

VS 150

66883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registration No. 66883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 W. Lanvale Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob E. Leister.

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Thelma L. Leister
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1890

8. AGE: Years	Months	Days	If less than one day
58	1	14	hr. min.

9. Birthplace: Hampstead, Md. (Town, county, and state)
10. Usual Occupation: Tavern
11. Industry or business: Self

FATHER
12. Name: Seymour Leister
13. Birthplace: Md.

MOTHER
14. Maiden Name: Lena ?
15. Birthplace: Md.

16 (a) Informant: Mrs. Vivian E. Fifer
(b) Address: Apt. 194, Edgewater Apts. Essex, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory: Meadowridge
Location: Howard Co., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 17 1948 (Date rec'd by Registrar) (b) [illegible], Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15 1948, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to Sept 15 1948, and that I last saw h[illegible] alive on Sept 15 1948.

Duration
Immediate cause of death: Myocardial infarction
Due to: Coronary thrombosis
Due to: Arteria-sclerotic H disease
Other Conditions: Adhesive pericarditis slight

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: Those mentioned above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Howard Lucher M.D.
Address: West Baltimore Date signed: Sept 16, 1948

Gent Hosp

G66884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66884

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 N. Duncan St.
(c) Hospital or institution: 7-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 N. Duncan St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ISIDOR GIBIAN.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Helen Gibian.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1872.

8. AGE: Years	Months	Days	If less than one day
75	9	19	hr. min.

9. Birthplace Checho-Slovakia. (Town, county, and state)
10. Usual Occupation Retired Tanner.
11. Industry or business

FATHER
12. Name ---------- Gibian.
13. Birthplace Checho-Slovakia.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Checho-Slovakia.

16 (a) Informant Mrs. Helen Gibian,
(b) Address 702 N. Duncan St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/48. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship.
Location Baltimore, Md.

18 (a) Funeral director
(b) Address 1902 E[illegible] Pk. Ave., Md.

19 (Date rec'd by registrar) SEP 17 1948 (Registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 16th. 1948 at 10.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1946 to Sept 16 1948 and that I last saw him alive on Aug 9 1948

Immediate cause of death Acute Cardiac Failure — Duration 15 mons.
Due to Arteriosclerotic Heart Disease — 5 yrs
Due to Generalized Arteriosclerosis — 10 yrs (approx.)
Other conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D. M. D.
Address 2413 E Monument St Date signed 9/16/48

VS 150

666885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 666885

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 E. 38th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 E. 38th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country London, England

3 (a) FULL NAME Florence Henry de Pothonier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18, 1863

8. AGE: Years 84 | Months 8 | Days 27 | If less than one day hr. min.

9. Birthplace London, England (Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Henry de Pothonier
13. Birthplace England

MOTHER
14. Maiden Name Jane C. Duncan
15. Birthplace England

16 (a) Informant Mrs A. Phillips
(b) Address 334 Rosaville Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 SEP 17 1948 (Date rec'd by registrar) (b) Baltimore, Md. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1948 at 9.20 p M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1946 to Sept 1948 and that I last saw him alive on Sept 16 1948.

Immediate cause of death	Duration
Arteriosclerotic Cardio-vascular Disease	Many years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. V. D. Mack M. D.
Address 513 E. 39th St Date signed 9.15.48

Certified, where applicable, in accordance with Sec. 251, Every item of information should be entered, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 666886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 Lorman Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15"
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Lorman Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE FLOYD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1913

8. AGE: Years	Months	Days	If less than one day
35	6	13	hr. min.

9. Birthplace Hartsville S. C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Aaron Floyd.
13. Birthplace Hartsville, S. C.

MOTHER 14. Maiden Name Julia Richardson.
15. Birthplace Hartsville S.C.

16 (a) Informant James Johnson
(b) Address 1803 Lorman

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18, 1948
(month) (day) (year)

(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Mrs Katy R Williams
(b) Address 3 N Schroeder St.

19 (a) SEP 17 1948 (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1948, at 5 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Heart Failure

Due to Hypertension + Diabetes

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

Signature Carl L Royer M.D.
Medical Examiner

Date signed 9-15-48

VS 151

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

666887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 666887

AB-121493

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.

(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1212 Smithson St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Waters.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 1- 1887

8. AGE: Years	Months	Days	If less than one day
61	5	12	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name	Eugene Waters
13. Birthplace	Md.
MOTHER 14. Maiden Name	Grace Bruce
15. Birthplace	Md.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9/19/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Randallstown

Location Randallstown, Md.

18 (a) Funeral director Wes. H. Nelson

(b) Address 1013 Runnymeade Rd

19 SEP 17 1948 (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13 1948 at 7.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22- 1948 to 9-13- 1948, and that I last saw him alive on 9-13- 1948.

Immediate cause of death Coronary thrombosis

Due to Arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/3/48

Major findings of operation: Perineal abscess

of autopsy:

Duration
5
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Norman Cole M.D.
M. D.

Address 4940 Eastern Ave Date signed 16 Sept 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66888

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66888 Registered No.

13 1a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Jessup (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Blanche Crone

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Husband - Charles | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-3-19

8. AGE: Years 29 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Etle
13. Birthplace Md.

MOTHER
14. Maiden Name Madeline Zinkhand
15. Birthplace Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18, 1948 (month) (day) (year)
(c) Cemetery or crematory St Lawrence Cemetery
Location Jessup, Maryland

18 (a) Funeral director De Witt Donaldson
(b) Address Laurel, Maryland

19 (a) SEP 17 [illegible] Registrar
Date rec'd by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1948, at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1948 to 9-15 1948 and that I last saw her alive on 9-15 1948.

Immediate cause of death Cardio-Respiratory failure - | Duration

Due to Chronic glomerulonephritis

Due to Toxemia -

Other Conditions & Hypertension - Ot. decisive

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. J. Venable Jr MD
Address St Agnes Hosp Date signed 9-15-48

VS 150

666389.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

+ 1179

✓ 666389 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catons
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 305 N. Bradeus (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

✓

3 (a) FULL NAME Henry Rackemperger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband or wife~~ Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14-78

8. AGE: Years	Months	Days	If less than one day
70	4	2	hr. 1 min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Mona

11. Industry or business

FATHER
12. Name Daniel - dec'd
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Arnold (dec'd)
15. Birthplace Md

16 (a) Informant Henry Rackemperger
(b) Address 305 Lanvale Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Geo. A. Farley
(b) Address Catonsville Md

19 (a) Date received by local registrar SEP 17 1948 (b) Registrar Baltimore, Md

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1948 to 9-15 1948. and that I last saw h alive on 9-15 1948.

Immediate cause of death Empyema

Due to Pneumonia,

Due to Bleeding Peptic Ulcer

Other Conditions

(Include) pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis A. Krieger Jr. M. D.
Address St. Agnes Hosp Date signed 9/15/48

×

666890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 666890

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 47 Kennedy Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey C. Gaither

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Virgie E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1889

8. AGE: Years	Months	Days	If less than one day
59	5	5	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Superintendent

11. Industry or business Construction Co.

FATHER
12. Name Harvey C. Gaither
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Carey
15. Birthplace Md.

16 (a) Informant Mrs. Virgie Gaither
(b) Address 47 Kennedy Lane

17 (a) Burial (b) Date thereof 9-20-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave. & Fayette St.

19 (a) SEP 17 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Sept. 1948, at 11:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed 16 Sept. 1948

VS 181

C66891

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. C66891

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St.
(c) Hospital or institution Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Longwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin H. Rozen Sr.

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married.

6 (b) Name of husband or wife Teresa Rozen.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6.

8. AGE: Years	Months	Days	If less than one day
57	1	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Theater Manager.
11. Industry or business

FATHER 12. Name John Rozen
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Conway
15. Birthplace Maryland

16 (a) Informant Teresa Rozen.
(b) Address 1701 Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20-1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Flynn-Fleming
(b) Address 1426 Light St.

19 (a) SEP 17 1948 (Date filed by Registrar) (b) Huntington Nellenyan, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16/ 1948, at 5:00 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/12/ 1948 to 9/16/ 1948, and that I last saw him alive on 19

Immediate cause of death
(a) Gastric hemorrhage
(b) Cerebral thrombosis
Due to Acute gastritis with multiple ulcers and erosion.
Due to Hemorrhagic arteriosclerosis
Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Duration
about 6 days.

Date of operation
Major findings of operation:
of autopsy: See under # 21

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. P. Fineman M.D.
Address 1319 Light St. Date signed 9/16/48

836

666892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No. 666892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 Appleton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Appleton Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harrison Jackson Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1922

8. AGE: Years	Months	Days	If less than one day
26	-	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Harrison Jackson
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Effie Vessels
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Effie Baylor
(b) Address 1814 Appleton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- 18- 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn Maryland

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 Mcculloh Street

19 (a) SEP 19 1948 (Date received by Registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16/ 1948 at 1.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12/1948 to 9/16 1948 and that I last saw h alive on 9/15/1948.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to T.B.C.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 1300 N. Grant St Date signed 9/17/48

VS 150

666893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c ✓

Registered No. 666893

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 Madison Ave.
(c) Hospital or institution: Bar-Wil- Ba Convenience Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 Fitting Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nellie V. Bond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 4, 1869

8. AGE: Years	Months	Days	If less than one day
78	10	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Tabb
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Lavinia Mars
15. Birthplace Baltimore, Maryland

16 (a) Informant Carlse B. Patterson
(b) Address 222 Fitting Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Charles R. Law
(b) Address 862 Madison ave.

19 (a) Filed SEP 17 1948 (Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1948, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1947 to Sept 15 1948 and that I last saw her alive on Sept 15 1948

Immediate cause of death Chronic Arthritis — Duration 2 yrs.

Due to Cardio Vascular Disease — Duration 1 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence, at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify Yes or No)
(e) Means of injury

23. Signature William Frey M.D.
Address 1928 Penna Ave Date signed Sept 16/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 26618

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

541

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 Caroline Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN GREENWOOD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 16 1948

18 (a) Funeral director Cumberland W. Hall
(b) Address

19 SEP 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1948 at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inq thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work)
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner
Date signed 9-3-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 66895

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: University Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. Stevenson Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Reynolds

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 9-12-48

8. AGE: Years | Months | Days: 3 | If less than one day: ____ hr. ____ min.

9. Birthplace: University Hospital (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name: Alexander Mitchell
13. Birthplace

MOTHER — 14. Maiden Name: Doris Mae Reynolds
15. Birthplace

16 (a) Informant: Mother
(b) Address: Stevenson Md.

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 SEP 17 1948 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-16- 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1948, to 9-16 1948, and that I last saw her alive on 9-16 1948.

Immediate cause of death: Prematurity

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: P a Peterson M. D.
Address: University Hosp Date signed 9-16

666896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56E

Registered No. 666896

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County CALVERT
(c) City or town OWINGS (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No. Yes or No
If yes, name country

3 (a) FULL NAME BARBARA ELLEN KRATZ

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 3, 1932

8. AGE: Years	Months	Days	If less than one day
16	6	13	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation STUDENT
11. Industry or business

FATHER
12. Name WILLIAM S. KRATZ
13. Birthplace Md. (Balto.)

MOTHER
14. Maiden Name Edith OWINGS
15. Birthplace Md. (Calvert Co.)

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory Friendship Meth. Cem.
Location Friendship, A. A. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 SEP 17 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 16 1948 at 7:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1948 to 9-16 1948. and that I last saw HER alive on 9-16 1948.

Immediate cause of death Brain tumor
Due to (Craniopharyngioma)
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation 15 Sept 1948
Major findings of operation: Brain tumor
of autopsy: Brain tumor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature H. K. Silver M.D.
Address Johns Hopkins Date signed 9/17/48

VS 150

666897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 666897

GM 121439

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2412 Whitbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Francis Kelly

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: W.
6 (b) Name of husband or wife: Mary Ann Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1862

8. AGE: Years 85 | Months 10 | Days 13 | If less than one day: hr. min.

9. Birthplace MD. (Baltimore) (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Thomas H. Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen McCabe
15. Birthplace Ireland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 17 19 (Date rec'd by registrar) (b) Thurston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-16- 19 48, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30- 19 48, to 9-16- 19 48, and that I last saw him alive on 9-16- 19 48.

Immediate cause of death Uremia — Duration: Wks

Due to Chronic Renal failure — Duration: months

Due to Generalized Arteriosclerosis — Duration: yrs

Other Conditions Gangrene R foot — Duration: 2 wks

(Include pregnancy within 3 months of death)

Date of operation 8-10-48

Major findings of operation: Gangrene R foot

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wyda A Pitcher M.D. M. D.
Address Baltimore City Hosp. Date signed 9-16-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66898 JL -

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G66898

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 31
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 S. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Byrd -Ophelia

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1948

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George
13. Birthplace Md.

MOTHER
14. Maiden Name Ophelia Moses
15. Birthplace ?

16 (a) Informant E. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9-16-48 (month) (day) (year) 7 AM
(c) Cemetery or crematory B. C. H. Crematory
Location 4940 Eastern ave

18 (a) Funeral director B C H. Crematory
(b) Address

19 (a) SEP 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Sept. 13 1948, at 10.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 1948 to Sept. 13 1948, and that I last saw him alive on Sept. 13 1948

Immediate cause of death Prematurity — Duration 36 hrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Fetal atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. N. Evans M.D.
Address Date signed Sept. 18

VS 150

correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

BC-48-17288

66899

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66899

157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt - 21
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 Bank St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Frank Kaczorowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-10-48

8. AGE: Years	Months	Days	If less than one day
	1	7 38	hr. min.

9. Birthplace Balt. Md.
(Town, county, and state)
10. Usual Occupation infant
11. Industry or business

FATHER
12. Name James Joseph Kaczorowski
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Barbara Veronica Wojcik
15. Birthplace Baltimore, Md.

16 (a) Informant Birth certificate
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozazewski
(b) Address 1930 Eastern Ave

19 (a) SEP 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17 1948, at 12:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10 1948 to 9-17 1948, and that I last saw him alive on 9-17 1948.

Immediate cause of death Cardiac failure — Duration

Due to Congenital Heart Disease Probable Intussusception

Due to Septicemia

Other Conditions
(Including pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben Bass M.D.
Address University Hospital Date signed 9-17-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

166900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. 166900

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 731 Argonne Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles L. Fowler

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-2208

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-31-86

8. AGE: Years	Months	Days	If less than one day
61 62	8	16	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Kenneth Fowler
13. Birthplace ?

MOTHER
14. Maiden Name Lucy ?
15 Birthplace ?

16 (a) Informant Kenneth Fowler (son)
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) SEP 18 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-16 — 1948 at 9 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10- 1948 to 9-16- 1948, and that I last saw him alive on 9-16 - 1948.

Immediate cause of death: Cardiac failure — Duration: 5 days

Due to: Rheumatic heart disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Mitral & aortic stenosis & insufficiency, chronic passive congestion of liver and kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allyn M. Judd M. D.
Address Mercy Hosp Date signed 9-16

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 184

Registered No. 666901

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pulaski & Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 S. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES EISENACHER, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-28 3806

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1931

8. AGE: Years	Months	Days	If less than one day
17	3	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Apprentice

11. Industry or business Brush Maker

FATHER
12. Name Charles M. Eisenacher, Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret M. Walters
15. Birthplace Baltimore, Md.

16 (a) Informant Margaret M. Eisenacher
(b) Address 205 S. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20-1948 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director B. M. Walters & Sons
(b) Address Pratt & Fremont Sts

19 (a) SEP 18 1948 (Date received by registrar) (b) Remington for Milanese, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1948, at 9:17 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to Bullet wound of Abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 16/48 7:30 P.M.
(b) Where did injury occur? 205 S. Pulaski St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury firearms

23. Signature Emil L. Rayle M.D.
Medical Examiner.
Date signed 17 Sept 48

VS 151

666902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 111c

Registered No. 666902

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 Lamont Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SHIRLEY ANN (SHAFFER) SHAFFER djm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 11th 1939

8. AGE: Years	Months	Days	If less than one day
9	6	4	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles N. Shaffer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Martha M. Reed
15. Birthplace Md.

16 (a) Informant Martha M. Shaffer
(b) Address 1738 Lamont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory Morland Park
Location Parkville, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15, 1948, at 9.50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Edema of brain
Edema of lungs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (White or Black)
(d) Means of injury

23. Signature George H. Pierce M.D. Medical Examiner.
Date signed September 16, 1948

VS 151

Correct age in especially important. Physicians: please write the cause of death clearly and legibly.

666903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 666903

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 Charolett Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EVA Isabelle SCHELLENSCHLAGER

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife Mathias

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1891

8. AGE: Years	Months	Days	If less than one day
57	3	2 3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Constance
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Ellen V. Gordon
15. Birthplace Baltimore, Maryland

16. (a) Informant: Eva Ellen Schellenschlager
(b) Address 1604 Charlott Avenue

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Sept. 20,48 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Memorial
Location Dorsey, Maryland

18 (a) Funeral director William Cook, Inc.,
(b) Address 1217 St. Paul Street

19 SEP 18 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1948 at 12.05a M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute congestive Heart Failure

Due to Coronary artery Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rose M.D.
Medical Examiner.
Date signed 9-18-48

VS 151

666904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 666904

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles Street
(c) Hospital or institution:
Doctors Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 354 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Pearl Beck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	

6 (b) Name of husband or wife Christian Beck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) FEB 18, 1896

8. AGE: Years 52 | Months | Days 29 | If less than one day hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation Restaurant owner

11. Industry or business Self

FATHER
12. Name Louis Jones
13. Birthplace Kentucky

MOTHER
14. Maiden Name Rich
15. Birthplace Kentucky

16 (a) Informant Helen Rogers
(b) Address 354 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director John Cook Inc.
(b) Address 1217 St Paul St.

19 (a) SEP 18 1948 (Date rec'd by registrar) (b) Courtney Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17/48 19 . at 7:12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 19 48 to Sept 17 1948 and that I last saw h alive on Sept 17 1948

Immediate cause of death: Acute Heart Failure — Duration 2 days.
Due to myocardial degeneration 1 yr
Due to arteriosclerosis —
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature John A. Sloan M. D.
Address 876 Cathedral Date signed 9/17/48

VS 150

66905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1641

Registered No. 66905

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens + Caton Aves.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Howard

(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)

(d) Street No. Route #2 (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Maude Lilly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Husband - Floyd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-17-1876

8. AGE: Years 72 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Brethyon

FATHER 13. Birthplace England

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace " "

16 (a) Informant Mrs Emily Phelps

(b) Address 2209 N Gaitongall st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-48 (month) (day) (year)

(c) Cemetery or crematory St Johns

Location Howard County

18 (a) Funeral director E. C. Higinbotham

(b) Address Ellicott City Md

19 (a) SEP 18 1948 (Date rec'd by registrar) (b) Turington-Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1948 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13-48 to 9-15-48.

and that I last saw her alive on 9-15-48

Immediate cause of death Tracheal Edema

Duration

Due to Self-inflicted wound.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/13/48

Major findings of operation: Severance of trachea (partial)

of autopsy: Tracheal edema

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Suicide

(b) Date of occurrence 9/13/48 at 5 P M

(c) Where did injury occur? Ellicott City (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work?

(e) Means of injury RAZOR

23. Signature Stephen H. Framm M. D.

Address St. Agnes Hospital Date signed 9-16-48

Certified for Dr. Wm. Helfrich by Thomas J. Madden, M.D.

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

66906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 66906

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood Sts.
(c) Hospital or institution:
(D.O.A.) University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2804 Erdman Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Aloysius McShane

3 (b) If veteran, name war World War #1

3 (c) Social Security Account No. 215-10-0873

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen K. McShane
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) March-19-1889

8. AGE: Years	Months	Days	If less than one day
59	5	29	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Revere Copper & Brass Works

FATHER
12. Name John F. McShane
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary J. Affayroux
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Helen K. McShane (wife)
(b) Address 2804 Erdman Ave., City #13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept-20-1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave., City #1

19 SEP 18 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Sept. 1948, at 7:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Exo death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kamma Jr. M.D.
Medical Examiner.
Date signed 17 Sept. 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 191

666907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12a

Registered No. 666907

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 S. Collins Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 S. Collins Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mungo Duncan Wyper

3 (b) If veteran, name war —
3 (c) Social Security Account No. 169-07-2213

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Janet S. Wyper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1901

8. AGE: Years	Months	Days	If less than one day
47	5	14	hr. min.

9. Birthplace Galston, Scotland
(Town, county, and state)
10. Usual Occupation Mustard Miller
11. Industry or business McCormick & Co.

FATHER
12. Name Robert L. Wyper
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Duncan
15. Birthplace Scotland

16 (a) Informant Mrs. Janet S. Wyper
(b) Address 508 S. Collins Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Easton Lane
(b) Address Ellicott City, Md.

19 (a) SEP 18 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1948; at 3.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 July 1948 to 16 Sept 1948, and that I last saw him alive on 15 Sept 1948.

Immediate cause of death Pulmonary silicosis — Duration 5 yrs +

Due to

Due to

Other Conditions Pulmonary tuberculosis?? — 1-2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 20 E. Preston St. Balt. Date signed 17 Sept 48

VS 150

G66908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G66908

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner Ave & Dukeland St

(c) Hospital or institution: West Baltimore General Hosp. 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1313 Wilcox
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mrs. Ozane Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife George M. Watson

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr) March 25, 1891

8. AGE: Years	Months	Days	If less than one day
57	5	22	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name John Wilson
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Angie Busby
15. Birthplace Baltimore Md.

16 (a) Informant George M. Watson

(b) Address 1313 Wilcox St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18 1948 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem

Location East End of North Ave

18 (a) Funeral director Edwin McCollin

(b) Address 924 E. Eager St.

19 (a) SEP 18 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 1948, at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1948, to 9/16 1948; and that I last saw h[illegible] alive on 9/16 1948.

Immediate cause of death	Duration
Cardiac failure	1
Due to Hypertensive Cardiovascular dis	
Due to Uremia	1
Due to Nephrosis (sulfa toxicity)	
Due to Stomach Hepatitis	
Other Conditions Arteriosclerotic heart dis	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address West Balto Hosp Date signed 9-17-48

VS :50

66909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 66909

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Corner Lafayette ave & John St

(c) Hospital or institution:

Hospital for the Women of Maryland.

(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Cockeysville (If outside city or town limits, write RURAL and give town)

(d) Street No. Box 34 (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Jennie Loretta Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ W. J. Bowen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 24, 1865

8. AGE: Years	Months	Days	If less than one day
82	9	24	23 hr. min.

9. Birthplace Towson Md. (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER

12. Name Westley German

13. Birthplace Not Known

MOTHER

14. Maiden Name Alia Bowen

15. Birthplace Not Known

16 (a) Informant Son, W. J. Bowen

(b) Address Box 34 Cockeysville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20-1948 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill

Location Towson Md

18 (a) Funeral director John Byrne Sons.

(b) Address 610 York Rd Huntington Woodlawn, Md

19 SEP 13 1948 (b) Registrar

(Date filed by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1948 at 9:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 17 1948, to 19..., and that I last saw ~~him~~ her alive on Sept 17 1948.

Immediate cause of death Peritonitis — Duration

Due to Carcinoma of Cecum —

Due to

Other Conditions Fibroid Uterus Senile arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma of Cecum

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Mark E. Hall, J M. D.

Address Women's Hospital Date signed 9/18/48

VS 150

66910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

66910
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 St. Paul St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph M. Holehan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Duena V. Holehan 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 4th 1876

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72	6	12		

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Field Deputy
11. Industry or business Internal Revenue Dept.

FATHER
12. Name John E. Holehan
13. Birthplace England

MOTHER
14. Maiden Name Margaret B. (Unknown)
15. Birthplace Ireland

16 (a) Informant Duena V. Holehan
(b) Address 2015 St. Paul St.

17 (a) Burial (b) Date thereof Sept 20 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave Ext

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 18 1948 (b) Thomas Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16th 1948, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to Sept 16 1948, and that I last saw h in alive on Sept 16 1948.

	Duration
Immediate cause of death: Cerebral thrombosis	4 days
Due to: Arteriosclerosis &	
Due to: Chronic hypocardiatis	1 year
Other Conditions: Leukoplakia of Mouth.	1 year

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gerth Mortimer Jr Md M. D.
Address 2306 St Paul St Date signed 9/18/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 66911

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution: Lauder Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town 2834 Guilford Avenue
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Maryland
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE MARY WERNER FAIR

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Dr. Horace L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1883

8. AGE: Years	Months	Days	If less than one day
64	9	0	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Publistenographer
11. Industry or business Self

FATHER
12. Name George P. Werner
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name A. M. Ingram
15. Birthplace Virginia

16 (a) Informant George Werner
(b) Address 2 East Lexington St.

17 (a) Burial (b) Date thereof Sept. 20, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) SEP 18 1948 (b) Huntington Pharmacy Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16 1948, at 10:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1948 to Sept 16 1948 and that I last saw h alive on Sept 16 1948.

Immediate cause of death Cerebral hemorrhage
Antecedent causes
Due to Cardiac hypertrophy

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: No

Duration
12 hours
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. E. Jones M.D.
Address 2818 St Paul Date signed 9/17/48 M. D.

X

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 66912

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3031 St. Paul St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL EDMONDS (SAMUEL WARING EDMONDS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, (widowed) or divorced. Widower

6 (b) Name of husband or wife Catherine Connolly Edmonds

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1866

8. AGE: Years 81 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Samuel Edmonds
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Julia Pouder
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Charles Moyer Gardiner
(b) Address 3031 St. Paul street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Chas. J. Evans - Son
(b) Address 418 N. Mt. Royal Ave

19 SEP 18 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1948, at 1.00 A.M.

21. I certify that I took charge of the remains described above, held an partial autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull & cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 12/2

(a) Date of injury 9-16-48 at approx. 12.00 P. M.
(b) Where did injury occur? 3031 St. Paul St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
Means of injury Fell down steps

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12-29-48

VS 15t

666913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 666913

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. 33d and Calvert Sts.
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Riderwood, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sherwood Rd.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME John Leland Sebald

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 318-03-3660

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Elsie L. Sebald

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Sept. 2, 1898

8. AGE: Years 50 | Months 0 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Illinois (Chicago)
(Town, county, and state)

10. Usual Occupation Vice President

11. Industry or business Commercial Credit Co.

FATHER
12. Name Benno William Sebald
13. Birthplace Plymouth, Wisc.

MOTHER
14. Maiden Name Harriet E. May
15 Birthplace Watertown, Wisc.

16 (a) Informant Mr. Leslie E. Sebald
(b) Address Ridgewood, N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 SEP 18 1948 (Date rec'd by registrar) (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 17 1948 at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 1948 to 9-17 1948 and that I last saw him alive on 9-17 1948

Immediate cause of death Pulmonary edema and shock — Duration

Due to Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. P. Benson, Jr. M. D.
Address 33d & N. Calvert Date signed 9-17-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66914 Registered No. 1219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Mohawk Ave.
(c) Hospital or institution: Anderson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4411 Groveland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: MARY JANE GRANT

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Dec. 8, 1864

8. AGE: Years 83 | Months 9 | Days 9 | If less than one day hr min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER 12. Name: Michael J. Grant
FATHER 13. Birthplace: Ireland

MOTHER 14. Maiden Name: Ellen Haney
MOTHER 15. Birthplace: Ireland

16 (a) Informant: Mrs. Howard Sanders
(b) Address: 4411 Groveland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory: Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by Reg.) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 17, 1948 at 4:45a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1948 to Sept 17 1948, and that I last saw her alive on Sept 16 1948

Immediate cause of death	Duration
Uraemia	5 d
Bronco Pneumonia (DECUBITUS)	2 d
Due to Mitral Regurgitation (HYPERTENSION)	14 d
Arteriosclerosis	14 d
Due to Chronic Interstitial Nephritis (NEPHRITIS)	14 d
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: F. A. Stevens M. D.
Address 2878 Harford Ln Date signed 9-17-48

VS 150

Please write plainly, with pen and ink. Every item of information should be entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 R

Registered No. 66915

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 S. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 S. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence E. Burgess

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 18th 1887

8. AGE: Years	Months	Days	If less than one day
61	6	30 29	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Embalmer
11. Industry or business John J. Cowan & Son

FATHER
12. Name John H. Burgess
13. Birthplace Laurel Md

MOTHER
14. Maiden Name Sarah A. Mason
15. Birthplace Washington D.C.

16 (a) Informant Mrs Anna M. Burgess
(b) Address 208 S. Gilmor, Lft.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/48 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location 3801 Frederick Ave

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St

SEP 18 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17th 1948 at 1 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to Sept 17 1948, and that I last saw h[illegible] alive on Sept 17, 1948

Immediate cause of death	Duration
Respiratory Failure	several days
Due to Passive Congestion	several yrs.
Due to Chron. Myocarditis and Cirrhosis of Liver	several yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abram Goldman
Address 206 S. Gilmor St Date signed Sept 18, 48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. 66916

LcH 119120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 46

2. USUAL RESIDENCE OF DECEASED:
(a) State ... (b) County ...
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No home
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country ...

3 (a) FULL NAME JAMES HAMBERRY

3 (b) If veteran, name war ...
3 (c) Social Security Account No. ...

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Annie L.
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr) Oct. 2, 1879

8. AGE: Years	Months	Days	If less than one day
68	11	4/14	hr. ... min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business B. O. R.R.

FATHER
12. Name Martin Hamberry (d)
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Birmingham (d)
15. Birthplace Ireland

16 (a) Informant Records Balto. City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Laurel (b) Date thereof 9/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Gwynn Son
(b) Address 2011-03 Hollins St.

19 SEP 18 1948 (b) Huntington Maryland
(Date rec'd by registrar) Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1948, at 1:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22/48 19 ... to 9/16 19 48 and that I last saw him alive on 9/16 19 48.

Immediate cause of death Hemorrhage — Duration 2 days
Due to Carcinoma of Bladder — ?
Due to ...
Other Conditions ...
(include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: ...
of autopsy Ca Bladder, Central edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury ...

23. Signature Norman J. Cole M.D. M. D.
Address 4940 Eastern Ave Date signed 9-17-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66917 W&SP

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. 66917

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1266 Sargent St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WOOD (mp)

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2nd 1907

8. AGE: Years 40 Months 9 Days 15 If less than one day hr. min.

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Columbia Florist

FATHER
12. Name George Wood
13. Birthplace Scotland

MOTHER
14. Maiden Name Unknown
15. Birthplace Scotland

16 (a) Informant: Mrs Mary M. Wood
(b) Address 1266 Sargent St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Frederick Ave

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.

19 (a) SEP 18 19 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1948 at 1.55 A M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Apoplexy Subarachnoid Hemorrhage

Due to Hypertension C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed 9-19-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 131

66918
AB-122736

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

66918
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 N. Paca St. (Nursing Home)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Throphalus Kelly

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11- 1871

8. AGE: Years 77 | Months 2 | Days 26 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name John Kelly (D
13. Birthplace N.C.

MOTHER
14. Maiden Name Lizzie Webb (D
15. Birthplace Ireland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-18-48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location Hernandez Hill Rd.

18 (a) Funeral director Charles S. Quilici
(b) Address 901 S. Conkling St.

19 SEP 18 1948 (Date rec'd by registrar) Huntington Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7- 1948 at 6.50 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-6- 1948 to 9-7- 1948 and that I last saw him alive on 9-7- 1948

Immediate cause of death — Duration
Acute heart failure
Due to Arteriosclerotic heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: Tuberculosis of lungs, far advanced

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. P. Telfer M.D. M. D.
Address Balto City Hosp Date signed 9-17-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

666919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

666919 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1928 Riggs Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS Wesley POPE

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If dive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1924

8. AGE: Years: 24 | Months: 2 | Days: 14 | If less than one day: hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Presser

11. Industry or Business

FATHER 12. Name Rev. Leroy Pope

13. Birthplace Va

MOTHER 14. Maiden Name Lucy Brown

15. Birthplace Va

16 (a) Informant Rev. Leroy Pope

(b) Address 1928 Riggs Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-18-48 (month) (day) (year)

(c) Cemetery or crematory Franklin, Va.

Location

18 (a) Funeral director W. Halstead Peed

(b) Address 918 Franklin Va.

19 SEP 18 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 1948, at 4 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Skull - Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-7-48 at 9.05 P. M.
(b) Where did injury occur? Rear of 1001 W. Fayette St. Baltimore
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Blunt force

23. Signature Earl L. Royer M.D.
Medical Examiner

Date signed 9-18-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G66920 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1106 Stricker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Since

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 No. Stricker Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eddie Carter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1899

8. AGE: Years	Months	Days	If less than one day
48 49	11	19	hr. min.

9. Birthplace Lancaster, Va
(Town, county, and state)
10. Usual Occupation Ice man
11. Industry or business

FATHER
12. Name Frank Carter
13. Birthplace Va.

MOTHER
14. Maiden Name Olivia Payne
15. Birthplace Va.

16 (a) Informant Mrs. Edmund Lawson
(b) Address 1106 Stricker St.

17 (a) Buried (b) Date thereof Sept 19 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lancaster, Va.
Location Lancaster, Va.

18 (a) Funeral director Geo. L. Nelson
(b) Address 1505 Pennsylvania Ave.

SEP 19 1948 (b)
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18, 1948 at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1948, to 9-17 1948, and that I last saw him alive on 9-18 1948.

Immediate cause of death Septic intoxication Duration

Due to Liver damage possible carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evan B. Sickels, M.D.

Address 601 No. Calhoun St. Date signed 9-18-48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66921 | 66921 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gun Factory
(c) Hospital or institution: Univ. Hosp

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Manchester (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME William C Bulbert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Laura Virginia Bulbert | 6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr) Feb. 17 1888

8. AGE: Years 57 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Carroll Co. Md (Town, county, and state)

10. Usual Occupation Carpenter Painter

11. Industry or business Grocer

FATHER
12. Name David Bulbert
13. Birthplace Carroll Co Md

MOTHER
14. Maiden Name Ida M. Patrick
15. Birthplace Maryland

16 (a) Informant Mrs. Laura Bulbert
(b) Address Manchester Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-45 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Manchester Md

18 (a) Funeral director Jacob Windis Sons
(b) Address Manchester Md

19 SEP 19 1945 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18 1945 at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1945 to 9-18 1945 and that I last saw him alive on 9-18 1945

Immediate cause of death Coronary Thrombosis — Duration

Due to arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Howard E Hall M.D.
Address Univ. Hosp Date signed 9/19/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

6422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

666922 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1535 W. Lanvale St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1535 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE K. TATE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 9, 1883

8. AGE: Years	Months	Days	If less than one day
65	5	6	hr. min.

9. Birthplace Westmoreland Co. Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Kelly
13. Birthplace Westmoreland Cp. Va.

MOTHER
14. Maiden Name Lucy Reid
15. Birthplace Westmorsland

16 (a) Informant William Tate
(b) Address 1535 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 19, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

SEP 19 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15 1948 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 12, 1948 to Sept. 15, 48 and that I last saw her alive on Sept. 15 1948

Immediate cause of death: Congestive heart failure — Duration: 6 weeks
Due to: Hypertensive Card-Vas dis. — Unknown
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George McDonald M. D.
Address 844 N. Carey St. Date signed 9/13/48

VS 150

G66923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66923 Registered No. 838

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3514 Cottage Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3514 Cottage Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora Cantor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Rev Harry Cantor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1874

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation:

11. Industry or business: House Wife

FATHER 12. Name: Aaron Jacob Adelman

FATHER 13. Birthplace: Russia

MOTHER 14. Maiden Name: Gertrude

MOTHER 15 Birthplace: Russia

16 (a) Informant: Miss Anna Cantor

(b) Address: 3514 Cottage Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 20, 1948 (month) (day) (year)

(c) Cemetery or crematory: Degel Israel Cemetery

Location: Lancaster Penn.

18 (a) Funeral director: Sol Levinson & Bros

(b) Address: 1124-1126 W North Ave

SEP 19 1948 (Date rec'd by local registrar) (b) Washington Heights, Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19/48 19 . at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 19 . to 9-19 1948, and that I last saw her alive on 9/18 1948.

Immediate cause of death: Cerebral Thrombosis — Duration: 4 days

Due to: Arteriosclerosis

Due to: Coronary Thrombosis

Due to:

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Meyer Bolton M. D.

Address 1320 Eutaw St Date signed 9-19-48

VS 159

BC-B 74619
666924

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

122B

Registered No. 666924

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Washburn Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Acron Ford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1943

8. AGE: Years	Months	Days	If less than one day: hr.	min.
5	4	18		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name James Wesley Ford, Jr.
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Lillian Pierce
15. Birthplace Martinsburg, W. Va.

16 (a) Informant Mrs. Lillian Ford (mother)
(b) Address 500 Washburn Ave., Balto 25, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mon., Sept. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Baltimore, Md.

18 (a) Funeral director H. Edward Evans
(b) Address 400 E. Chase St. Balto 39 Md.

19 (a) SEP 19 1948 (Date received by registrar) (b) Registrar [illegible]

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16/ 1948, at 11:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13/ 1948, to 9/16/ 1948, and that I last saw him alive on 9/16/48 19

Immediate cause of death: Cerebral edema — Duration
Due to Cause pending
Due to
Other Conditions Intussusception
(Include pregnancy within 3 months of death)
Date of operation Sept 13 + 16th, 1948
Major findings of operation: Intussusception
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature H. L. Wallenmeyer M. D.
Address St. Joseph. Hospital Date signed 9/17/48

Please write plainly, with unfading ink. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G66925

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St.
(c) Hospital or institution:
Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Battery Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert F. Willey

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-07-7650

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 23 Jul 1900

8. AGE: Years 48 | Months 1 | Days 13 | If less than one day — hr. — min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Ship yard worker (Fireman)

11. Industry or business Beth. Steel Corp.

FATHER
12. Name William Willey
13. Birthplace Balto - Md.

MOTHER
14. Maiden Name Lena SMITH
15. Birthplace Balto. - Md.

16 (a) Informant Edw. L. Willey (Bro.)
(b) Address 1409 Battery Ave, Balto 39 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 19 SEP 19 48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto. Co., Md.

18 (a) Funeral director C. H. Baumgardner
(b) Address 1600 N. Charles St. Balto 39

19 SEP 19 1948 (Date rec'd by registrar) (b) Huntington McDaniel M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Sep 1948, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Sep 1948 to 16 Sep 1948, and that I last saw him alive on 16 Sep 1948.

	Duration
Immediate cause of death Shock and Toxemia	1 hr.
Due to Intestinal obstruction	2 wks.
Due to Carcinoma, annular, of sigmoid & liver metastases	months.
Other Conditions Multiple polyposis & diverticulae of colon	years

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation ~~autopsy~~ Ruptured diverticulum @ cecum; pneumonia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: None
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph V. Calogno M. D.
Address Franklin Sq. Hosp. Date signed 16 Sep 48

VS 159

G66926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G66926 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Walkers + Caton Aves.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2 S. Calhoun St (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Edward Gates

3 (b) If veteran, name war

3 (c) Social Security Account No. 205-10-4084

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wife - Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-30-1879

8. AGE: Years 69 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business B&O RR

FATHER 12. Name John

13. Birthplace Md.

MOTHER 14. Maiden Name Virginia Robinson

15. Birthplace Md.

16 (a) Informant MRS LILLIAN GATES

(b) Address 2 S CALHOUN ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 21 '48 (month) (day) (year)

(c) Cemetery or crematory LORRAINE

Location WOODLAWN, MD

18 (a) Funeral director Harry A Wyche

(b) Address 4101 Edmondson Ave

19 (a) Filed (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1948 at 11:40 AM

21. I certify that death occurred on the date above stated: that I attended deceased from 9-14 1948 to 9-17 1948 and that I last saw h[illegible] alive on 9-17 1948.

Immediate cause of death: Cardio-respiratory failure — Uremia. — Duration

Due to Severe gastro-intestinal hemorrhage

Due to peptic ulcer

Other Conditions Arterio-sclerotic cardiovascular disease

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. J. Venable Jr. M.D.

Address St. Agnes Hospital Date signed 9-17

Subject age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

666927 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 S. Franklintown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 S. Franklintown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie F. Manger.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Married

6 (b) Name of husband or wife Wm. H. Manger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1882

8. AGE: Years	Months	Days	If less than one day
66	1	5	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or Business

FATHER
12. Name Late August Feuerherd
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Murbach
15. Birthplace Germany

16 (a) Informant Mr. Leroy A. Manger
(b) Address 124 S. Franklintown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave

19 I (a) [illegible] (b) [illegible] by registered [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1945 at 8.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Sept 16 1945 and that I last saw h alive on Sept 16 1945.

Immediate cause of death	Duration
(a) Intestinal obstruction of gallbladder & stomach	1 yr
Due to Carcinoma of Uterus	2 yrs
Due to	
Other Conditions none	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 720 W Mt Rd Date signed 9/17/45

VS 150

G66928 ✓ G66928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 Penrose Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 Penrose Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia A. Carney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Owen B. Carney, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1884

8. AGE: Years	Months	Days	If less than one day
64	4	15	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Anthony Hofstetter
13. Birthplace Md.

MOTHER
14. Maiden Name Josephine Veith
15. Birthplace Md.

16 (a) Informant Mr. Owen B. Carney
(b) Address 1806 Penrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry N. Lutzke
(b) Address 4101 Edmondson Ave.

SEP 19 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16/48. 19 at 12 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1948 to Sept 16 1948. and that I last saw her alive on Sept 16 1948.

Immediate cause of death: Carcinoma of the Oesophagus with metastases. — Duration ? ?
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address 1109 St Paul St Date signed 9/17/48

VS 150

Baltimore Md

666929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. 666929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude J. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Robert M. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1890

8. AGE: Years	Months	Days	If less than one day
58	6	19	hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name Owen Connor
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Sullivan
15. Birthplace Ireland

16 (a) Informant Mr. Robert M. Miller
(b) Address 10 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Luitzke
(b) Address 4101 Edmondson Ave.

SEP 20 1948 (a) (b) M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1948 to Sept 17 1948 and that I last saw h alive on Sept 17 1948.

Immediate cause of death: Carcinoma 3 head & pancreas.
Duration: 6 mo.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 8/2/48

Major findings of operation: Carcinoma 3 head & pancreas

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert F. Kellman M. D.

Address 6 E Biddle St Date signed 9/16/48

666930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

666930 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Wenth
(c) Hospital or institution University Hospital 5 West
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
Street No. 803 N Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Leo F. Adams Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-6615

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hilda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 11th 1902

8. AGE: Years 46 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Milk

11. Industry or business Black & Decker Co.

FATHER 12. Name Benj F. Adams
13. Birthplace Pa

MOTHER 14. Maiden Name Amelia (Unknown)
15. Birthplace Pa.

16 (a) Informant Hilda Adams.
(b) Address 803 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St.

SEP 20 1948

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18/48 19 ... at 12 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 19 48 to 9/18 19 48.
and that I last saw h/m alive on 9/18 19 48.

Immediate cause of death Respiratory failure

Due to Carcinoma Lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1 yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify two of these)
(e) Means of injury

23. Signature Joseph O'Hara M.D.
Address Univ. Hospital Date signed 9/18/48

VS 150

Please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1279a

Registered No. G66931

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert streets

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 628 East 31st Street
(If rural give location)

(e) Citizen of foreign country? no Yes or No
If yes, name country

3 (a) FULL NAME Franklin Eugene Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Mrs. Katherine E. Bell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1870

8. AGE: Years	Months	Days	If less than one day
78	4	24	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew J. Bell
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Ellen Watkins
15. Birthplace Maryland

16 (a) Informant Union Memorial Hosp. Records
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-48 (month) (day) (year)

(c) Cemetery or crematory London Pk
Location Baltimore Md

18 (a) Funeral director Wellington Cook Inc
(b) Address 17 E. St. Paul St.

19 (a) SEP 20 1948 (Date rec'd by registrar) Huntington Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1948. at 7:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5 1948, to Sept 18 1948, and that I last saw him alive on Sept. 18, 1948.

Immediate cause of death	Duration
Acute Coronary Occlusion	
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept 9, 1948.

Major findings of operation: Benign Prostatic Hypertrophy

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, etc.)

(e) Means of injury

23. Signature J. Frank Supplee M.D.

Address Union Memorial Hosp Date signed Sept 5, 48

VS 150

BROOME

666932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

666932 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So Baltimore Hosp 12+2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, give name of township and the town)
(d) Street No. 3214 Abell Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rodger Broome

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Myrtle E Broome

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16 1875

8. AGE: Years 69 | Months 11 | Days 10 | If less than one day hr. min. 3

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Consolidated Coal Co

FATHER
12. Name Roger G. Broome
13. Birthplace Virginia

MOTHER
14. Maiden Name Nannie
15. Birthplace Virginia

16 (a) Informant Myrtle E Broome
(b) Address 3214 Abell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Milligan Cook Inc
(b) Address 1617 St Paul St

19 SEP 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 Sept 1948 at 3:55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema
Arteriosclerosis

Due to

Other Conditions Acute gastric dilatation
Fract. left femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing X cause of death, fill in the following:
(a) Date of injury 9-1-48 at approx. 11.00 A.M.
(b) Where did injury occur? Carvel Beach, A.A.C.
(c) Did injury occur at home, on farm, industrial place, in public place? Neighbor's back yard While at work? No
(d) Means of injury Struck by tree

23. Signature Emil Rogers M.D. Medical Examiner
Date signed 12 Sept 48

PLEASE WRITE PLAINLY. Fill in all blanks. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

66933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66933

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 741 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Braun

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-11-1881

8. AGE: Years 67 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Joseph E. Tully

13. Birthplace Penn-

MOTHER 14. Maiden Name Rebecca H. Hamilton

15. Birthplace Md-

16 (a) Informant Mrs Mabel H. Price

(b) Address 13 Rochambeau Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore Md

18 (a) Funeral director William Cook Inc

(b) Address 1210 St. Paul St

19 (a) SEP 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Sept 1948, at 8.30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 18 Sept. 48.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

666934

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6000 Bellona Ave.

(c) ~~Hospital~~ or institution: Edgewood Nursing Home

(d) Length of stay in ~~hospital or~~ inst. (yrs., mos., or days) 8 mo.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. Hopkins Apts. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lucille M. Zell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife: Henry S. Zell Jr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 88

8. AGE: Years: about 60 | Months | Days | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER 12. Name: Benj. F. Mullikin

13. Birthplace: Md.

MOTHER 14. Maiden Name: Rosalena King

15 Birthplace: Md.

16 (a) Informant: Randolph C. Zell

(b) Address: 148 S. Hilton St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/21/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~: Loudon Park

Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.

(b) Address: 1310 St. Paul St.

19 (a) SEP 20 1948 Burial waiting for Permit Baltimore, Md. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Sept 6 1948, and that I last saw her alive on 17 Sept. 1948.

Immediate cause of death: Coronary Occlusion — Duration: 1 hr.

Due to: Arteriosclerotic-degenerative, Cardio-vascular disease — Duration: 2 Years

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Jay L. Zamoiski M. D.

Address: 2030 Eutaw Pl. Date signed 18 Sept 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 666935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3431 Shannon Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1869 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Regner
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife August J. Regner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26 1878

8. AGE: Years 70 | Months 6 | Days 2 2 21 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph Hofstetter
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Lepsper
15. Birthplace Germany

16 (a) Informant Emma Regner
(b) Address 1869 N. Gay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2330 Jefferson St.

19 (a) 20 19 48 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 19 48 at 6 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 47 to 9/17 19 48.
and that I last saw h alive on 9/16 19 48.

Immediate cause of death Arteriosclerotic Heart Disease
Due to Hypertensive Heart Disease.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration 10 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Sol Smith
Address 1223 E. North Date signed 9/17/48 M. D.

VS 150

666936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

Registered No. 666936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1042 Stockton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-1
(e) Length of stay in Baltimore (yrs., mos., or days) 26 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1042 Stockton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louella Ruth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Henry Ruth
(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) 1886 Feb

8. AGE: Years 62 | Months 6 | Days 1 | If less than one day: hr. min.

9. Birthplace: Passing, Caroline Co Va (Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business

FATHER
12. Name: Laurence Marfoard
13. Birthplace: Caroline Co Va

MOTHER
14. Maiden Name: Lucy Hayes
15. Birthplace: Caroline Co

16 (a) Informant: Mrs. Cooper
(b) Address: 1042 Stockton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 23 48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem
Location: Essex Co. Va

18 (a) Funeral director: James Addams
(b) Address: 1042 Stockton St

SEP 20 19[illegible] (Date rec'd by registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1948, at 5-20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1948 to Sept 17 1948
and that I last saw her alive on Sept 16 1948

Immediate cause of death: Tuberculosis of the Vertebra — Duration 2 mo

Due to: Psoas Abscess

Due to: Psoas

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. Edward Fisher M. D.
Address: 1612 E Monument Date signed: 9/18/48

Dr. Sawyer

66937

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G66937

1-21a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Road
(c) Hospital or institution:
Beach Hill Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Lerch Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Rebbel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John L. Rebbel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1863

8. AGE: Years	Months	Days	If less than one day
84	9	23	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Herman L. Blamberg
13. Birthplace Germany

MOTHER
14. Maiden Name Mary A. ?
15. Birthplace Germany

16 (a) Informant Mr. Wm. L. Rebbel
(b) Address 3307 Lerch Drive #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) SEP 20 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1948 to 9/17 1948, and that I last saw her alive on 9/17 1948.

Immediate cause of death Respiratory failure and Cardiac decompensation

Due to Arteriosclerotic Cardiovascular disease

Due to Lepheosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify type of place)
(e) Means of injury

23. Signature James J. Rebbel
Address 5106 Harford Rd. Date signed 9/18/48 M D

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

VS 152

666938 Janny

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. 666938

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3101 Glendale Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3101 Glendale Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Georginia Meley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife George Meley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 4, 1890

8. AGE: Years	Months	Days	If less than one day
58	2	13	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry Koch
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Deitzel
15. Birthplace Germany

16 (a) Informant Mr. George Meley
(b) Address 3101 Glendale Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) SEP 20 194 (b) Huntington [illegible], Md.
(Registered by Registrar)

VS 150

MEDICAL CERTIFICATION:

20. DATE OF DEATH Sept. 17th 1948 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to Sept. 17, 1948 and that I last saw h[illegible] alive on Sept. 17, 1948.

Immediate cause of death Carcinoma, Pancreas — Duration 6 mos.

Due to Generalized metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation May 1948

Major findings of operation: Carcinoma, head of pancreas

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify two)
(e) Means of injury

23. Signature Nathan Janney M.D.
Address 7101 Harford Rd. Date signed 9/11/48

G66939

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66939
Registered No.

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6308 North Point Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JESSE T. CROWDER

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 211-09-2777

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Effie V. Crowder

6 (c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Aug. 14, 1900

8. AGE: Years: 48 | Months: 1 | Days: 3 | If less than one day: hr. min.

9. Birthplace: St. Georges, Island, Md.
(Town, county, and state)

10. Usual Occupation: Cab Driver

11. Industry or business: Sparrows Point Cab Co.

FATHER
12. Name: Jesse T. Crowder Sr.
13. Birthplace: St. Georges Island, Md.

MOTHER
14. Maiden Name: Dolly Lankford
15. Birthplace: St. Georges Island, Md.

16 (a) Informant: Mrs Effie V. Crowder
(b) Address: Montgomery Rd., Elkridge, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 20, 1948 (month) (day) (year)

(a) Cemetery or crematory: Lorraine
Location: Woodlawn P.O., Md.

18 (a) Funeral director: Frederick A. Wolf
(b) Address: 1200 W. Lombard St.

19 (a) SEP 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 17, 19 48, 12.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured legs. (both tibiae and fibulae)
Fractured pelvis.
Due to Fractured ribs.
Petechial hemorrhages of brain
Other Conditions Terminal bronchopneumonia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-12-48 at 6.25 a. M.
(b) Where did injury occur? Old North Point Rd. in Baltimore
(c) Did injury occur at home, on farm, industrial place, or public place? public place While at work? no
(d) Means of injury: Pedestrian struck by auto

23. Signature: George H. Merrill M.D.
Medical Examiner.
Date signed: September 17, 1948

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. 66940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 529 S. Kenwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 S. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY WILLIAM KUES

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 218-09-5314

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary (Arnold) Kues

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1871

8. AGE: Years 76 | Months 9 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Chauffer - retired

11. Industry or business Continental Can Co.

FATHER
12. Name Henry Kues
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. George Stevens
(b) Address 529 S. Kenwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) [illegible] Registrar
Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1948 at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2- 1948 to 9-16 1948 and that I last saw h[illegible] alive on 9-16 1948.

Immediate cause of death: Carcinoma of prostate — Duration

Due to

Due to

Other Conditions asterion[illegible]
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John J Gould M. D.
Address 142 East ave Date signed 9/20/48

X

666941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

666941 Registered No. 200a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 S Milton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Anna Deugwillo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Felix Walter Deugwillo

6 (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) 8-15-97

8. AGE: Years	Months	Days	If less than one day
51	1	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Radomski
13. Birthplace Poland

MOTHER
14. Maiden Name Frances
15. Birthplace Poland

16 (a) Informant Deceased
(b) Address 519 S. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21 '48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill Road, Baltimore Co.

18 (a) Funeral director Stephen J. Galloway Inc.
(b) Address 1918 E. Renwood Ave

19 (a) SEP 20 1948 (Date rec'd by registrar) (b) Burlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1948, at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to Sept 18 1948, and that I last saw her alive on Sept 15 1948.

Immediate cause of death Hyperpyrexia — Duration

Due to Cause undetermined

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work) (Specify type of place)
(e) Means of injury

23. Signature John Rebkee M. D.
Address St. Joseph Date signed 9-18-48

X

VS 150

Please write plainly, with pen and ink. Do not use pencil. Physicians: please write the causes of death clearly and legibly. Be sure that information is complete and correct. Undertakers: please see that certificate is complete and correct in every respect. Be sure that age is correct. Physicians: please write the causes of death clearly and legibly. Be sure that age is especially important.

G66942

4754964

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

307

G66942
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 1545 McKean Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME India Granison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col	married

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years	Months	Days	If less than one day
36			hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation maid

11. Industry or business

FATHER
12. Name Lilton Wyche
13. Birthplace Va.

MOTHER
14. Maiden Name Betty Merritt
15 Birthplace Va.

16 (a) informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (b) Date thereof 9-20-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lawrenceville
Location Virginia

18 (a) Funeral director Eagner Sanders
(b) Address 1412 E. Preston St

19 (a) (Date received by local registrar) Sept 20 1948 Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 18 - 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17- 1948 to 9-18- 1948. and that I last saw her alive on 9-18- 1948.

Immediate cause of death Cardiac Failure — Duration

Due to ? Syphilitic aortitis

Due to

Other Conditions ? & Bacterial endocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D Winternitz M.D.
Address Date signed 9-19-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be entered correctly and legibly. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

VS 150

666943

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 9-21

666943 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2002 N. Washington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DAVID E. SMITH

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male,	white	widowed

6 (b) Name of husband or wife Elizabeth Smith nee Kraft
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Nov. 12, 1869

8. AGE: Years	Months	Days	If less than one day
78	10	5	hr. / min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name David E. Smith
13. Birthplace Md.

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Charles E. Smith, son
(b) Address Silver Springs, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 20 1948 (Date rec'd by registrar) (b) Burial Permit Issued by Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1948, at 2:45 PM

21. I certify that death occurred on the date above stated, that I attended deceased from September 15 1948, to September 17 1948, and that I last saw him alive on September 17 1948

Immediate cause of death: Cardio Respiratory Failure — Duration 2 days
Due to: General Hypertension and Cardio Vascular Disease — 1 year
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Rosenberg
Address 2015 E North Ave Date signed 9/18/48

666944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666944

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 S. Ann St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Rascuk or Roscut

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-2171

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Alexandria Rascuk

6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Not know

8. AGE: Years: 59 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russian (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business:

FATHER
12. Name: ? Rascuk
13. Birthplace: Russian

MOTHER
14. Maiden Name: Not know
15. Birthplace: Russian

16 (a) Informant: Mrs. Anna Melnick
(b) Address: 309 S. Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 21-48 (month) (day) (year)
(c) Cemetery or crematory: Holy Trinity Russian
Location: Elkridge, Md

18 (a) Funeral director: John A. Grebliunas Jr.
(b) Address: 423 S. Paca St

19 (a) SEP 20 1948 (Date rec'd by registrar) (b) Huntington Maryland, (M) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Sept. 1948 at 10 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 17 Sept. 48

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as directed on other side of this form. Any item of information unknown or doubtful should be reported as such. Do not abbreviate. Use figures for dates. Be sure that cause of death is stated in such terms as to show clearly the disease, injury, or complication which caused death. Indefinite or unsatisfactory terms, such as "old age," "senility," "exhaustion," "heart failure," "cardiac failure," "respiratory failure," "uremia," "convulsions," "coma," etc., are not satisfactory unless explained. Indefinite statements of contributory causes should be avoided. Operations should be mentioned only when performed for the condition causing death. Violent deaths must be reported to the coroner. Physicians: please write the causes of death clearly and legibly.

CORRECTED COPY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9-B

✓ G66945
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 W. MULBERRY St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DOROTHY MAE BRYANT (BLOW)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 9, 1947.

8. AGE: Years: One | Months: 4 | Days: 5 | If less than one day: hr. min.

9. Birthplace NORTH CAROLINA (Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business

FATHER
12. Name WOODMAN BLOW
13. Birthplace ?

MOTHER
14. Maiden Name JAMES ANNA BRYANT
15. Birthplace NORTH CAROLINA

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Gilmor St. Lt.

19 (a) (b) Registrar

Sept 20 1948

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 14 1948, at 5:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 1948 to 9-14 1948 and that I last saw h BR alive on 9-14 1948

Immediate cause of death Cardiac Failure — Duration

Due to Myocarditis of unknown etiology

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature John J. Ryan M.D.
Address Johns Hopkins Hosp. Date signed 9-15-48

PLEASE WRITE PLAINLY, with ordinary pen and ink. Do not use pencil. Be sure to answer every question. Please do not omit any information you may have regarding any item, and be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666946

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

666946
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 W. Pierce St.
(c) Hospital or institution: 1941
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 W. Pierce St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Horace Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife SUSAN Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 80 | Months | Days | If less than one day hr. min

9. Birthplace Essex County, VA. (Town, county, and state)

10. Usual Occupation Cement Finisher

11. Industry or business

FATHER 12. Name George Johnson

13. Birthplace King & Queen Co. Va.

MOTHER 14. Maiden Name Rebecca

15. Birthplace ? Virginia

16 (a) Informant Robert Henry Johnson

(b) Address 1701 Pierce Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N. Schroeder st.

19 Sept 20 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1948, at 2:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1, 1948. to Sept. 17 1948. and that I last saw h[illegible] alive on 9-16 1948.

Immediate cause of death: Cardiac Failure — Duration: Several days

Due to Cardio-Vascular Disease — Several mos.

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 O. Franklin St. Date signed 9-18-45

VS 150

666947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 666947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdale Avenue
(c) Hospital or institution:
Anderson Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 65 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 Merrymount Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Mahool

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-09-0392

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ada B. Mahool

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Jan-24-1874

8. AGE: Years 74 | Months 7 | Days 26 | If less than one day: hr. ..... min.

9. Birthplace Phoenix, Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name James Mahool
13. Birthplace Baltimore Co., Md.

MOTHER
14. Maiden Name Frances Hammond
15. Birthplace Baltimore Co., Md.

16 (a) Informant Mrs. Ada B. Mahool (wife)
(b) Address 21 Merrymount Road, City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept-21-1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Maryland.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Avenue, City #1.

19 (a) [illegible] 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1948, at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Sept. 18 1948. and that I last saw him alive on Sept 18 1948

Immediate cause of death Uremia — Duration

Due to Arteriosclerosis

Due to

Other Conditions Cerebral Hemor. (May 1946)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joshua W. Hanson M. D.
Address 1109 St. Paul St. Date signed 9-20-48

VS 150

G66948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G66948

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 600 S. Chapel Gate Lane

(c) Hospital or institution: PINECREST SANITARIUM

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 MOS 17 days

(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No 1526 Falto St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME SIMON ZALESCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation SEXTON, SYNAGOGUE

11. Industry or business

FATHER 12. Name Hermann

13. Birthplace Poland

MOTHER 14. Maiden Name Not Known

15. Birthplace Poland

16 (a) Informant Esther Zalesch

(b) Address 102 E. Falto St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-20-48 (month) (day) (year)

(c) Cemetery or crematory United Hebrew

Location Washington Boulevard

18 (a) Funeral director Jack Rosenberg

(b) Address 2106 Eutaw Place

SEP 20 1948 (Date rec'd by registrar)

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 20 1948, at 6 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 1948, to 9-20-1948, and that I last saw him alive on 9-19 1948.

Immediate cause of death BRONCHO-PNEUMONIA — Duration 20 HOURS

Due to

Due to

Other Conditions MANIC EXCITEMENT 10 WEEKS

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Helmut Krager M. D.

Address 1308 Eutaw Place Date signed 9/21/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G66949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66949
Registered No. 1316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Levindale 27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME HYMAN RAINESS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Beulah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Mrs. Rainess
(b) Address 382 Pall Mall Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-48 (month) (day) (year)

(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jacob Reavis Inc
(b) Address 2400 Eutaw Place

SEP 20 1948

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19 1948 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1945 to 9-19 1948 and that I last saw h(im) alive on 9-19 1948

Immediate cause of death Chronic nephritis

Due to

Due to

Other Conditions Chronic cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Home Date signed 9-19-48

G66950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

G66950
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1566 Clifton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1566 Clifton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Dinges

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Frank —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-15-1911

8. AGE: Years 37 | Months 7 | Days 0 | If less than one day hr. mn.

9. Birthplace Baltimore - Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Unkelbach
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Meehan
15. Birthplace Unknown

16 (a) Informant Frank Dinges
(b) Address 1566 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-48 (month) (day) (year)

(c) Cemetery or crematory Pleasant View
Location Baltimore Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

SEP 20 1948 (b) (Registrar)

VS 15!

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 48, at 6.25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fatty Degeneration of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. L. Roy M.D.
Medical Examiner.
Date signed 9-22-48

66951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 66951

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 924 N Calvert St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 -
(e) Length of stay in Baltimore (yrs., mos., or days)

USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 N Calvert St (If rural give location)
(e) Citizen of (foreign country)? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Ballantine BALLANTYNE mp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Samuel Ballantyne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11, 1881

8. AGE: Years 67 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Wilmington Del (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Andrew Reed
13. Birthplace Del

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Elizabeth Owens
(b) Address 924 N Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23-45 (month) (day)

(c) Cemetery or crematory Mount Solem
Location Wilmington Del

18 (a) Funeral director Chas S Powell
(b) Address 1427 Edmondson Ave Balto Md

19 SEP 20 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1945, at 2 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Heart Failure

Due to A.S.C.V.D. - Hypertension of long standing.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Reyn M.D. Medical Examiner
Date signed 19 Sept 20

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. All correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66952 Registered No. 117a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 106 W. University Pkwy. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Albert E. Jenifer
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced sep.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-15-82
8. AGE: Years 65 | Months 11 | Days 12 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Elevator Operator
11. Industry or business

FATHER
12. Name Phillip Jenifer
13. Birthplace Md

MOTHER
14. Maiden Name Matilda Simms
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/48 (month) (day) (year)
(c) Cemetery or crematory Ebenezer
Location St Mary's Co Md

18 (a) Funeral director Wm J Jackson
(b) Address 916 Penna Ave

SEP 21 1948 (Date rec'd by registrar) Burlington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1948, at 2 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/23 1948 to 9/17 1948 and that I last saw him alive on 9/17 1948.

Immediate cause of death: Pulmonary infarction — Duration: 3 weeks.
Due to: due to pulmonary embolus following
Due to: operation for peptic ulcer
Other Conditions
(Include pregnancy within three months of death)
Date of operation 8/26/48
Major findings of operation: Gastric ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas N P Johns
Address Johns Hopkins Hosp Date signed 9/17

VS 150

Please write plainly with pen or pencil. Physicians: please write the causes of death clearly and legibly. Be sure that age is especially important.

G66953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G66953 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and fully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: ST. Joseph 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18days
(e) Length of stay in Baltimore (yrs., mos., or days) 23yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 E. Lanvale ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hazel Evaline Mickens

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-2-14

8. AGE: Years	Months	Days	If less than one day
33	10	16	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Henry Johnson Sr
13. Birthplace

MOTHER 14. Maiden Name Alice Burrell
15. Birthplace Va

16 (a) Informant Diseased
(b) Address 412 E. Lanvale ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Anne Arundel Co. Md

18 (a) Funeral director Morris A. Hensley
(b) Address 518 W. Biddle St.

19 (a) SEP 20 1948 (Date received by Local Registrar) (b) Huntingtor Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1948 at 1 25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1948 to 9-18 1948, and that I last saw her alive on 9-18 1948.

Immediate cause of death	Duration
Renal Azotemia	
Due to Malignant Hypertension	
Due to Arteriolar Nephrosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Rutkaye M. D.
Address St. Joseph Date signed 9-18-48

VS 150

66954 66954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 156 N. Potomac D.O.A St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 156 N Potomac St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J. (~~Holzhauer~~) Holzhaus

3 (b) If veteran, name war: World War - I
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/20/[illegible]

8. AGE: Years: 59 | Months: 1 | Days: 28 | If less than one day: hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Brewery Worker
11. Industry or business National Brewery

FATHER
12. Name Bernard Holzhaus
13. Birthplace Balto.

MOTHER
14. Maiden Name Eliz. Stock
15. Birthplace Balto.

16 (a) Informant Bernard Holzhaus
(b) Address 156 N. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Kelly & Zeller
(b) Address 403 E. Lafayette Ave, Baltimore, Md

19 SEP 20 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 1948, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Renal disease

Due to

Other Conditions Chronic Alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/19/48

VS 151

MILBURN

G66955 ✓ G66955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

838 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Hanover St
(c) Hospital or institution: Provident 17-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702-George St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Smith Milburn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John

6 (c) If married, widowed, or divorced, age years

7. Birth date of deceased (mo., day, yr.) ? ? 1916

8. AGE: Years 32 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Stanley L. Smith

13. Birthplace Md.

MOTHER 14. Maiden Name Lillie Foote

15. Birthplace Md.

16 (a) Informant Robert Foote

(b) Address 702- George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-48 (month) (day) (year)

(c) Cemetery or crematory Md. Auburn

Location & Halstead

18 (a) Funeral director 918- Druid Hill

(b) Address

19 (a) SEP 20 1948 (registrar) (b) Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17- 19 48 at ?? M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-0 19 48 to 9-17 19 48 and that I last saw h[illegible] alive on 9-17 19 48

Immediate cause of death, Cerebral Hemorrhage

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 9-20-48

VS 150

G669:56

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G669:56

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Pylesville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Walter

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr) 10-18-76

8. AGE: Years 71 | Months 72 | Days 11 | If less than one day: hr. 2 min.

9. Birthplace: Md (Town, county, and State)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Laban Lavue
13. Birthplace: Md

MOTHER
14. Maiden Name: Margaret Taylor
15. Birthplace: Md

16 (a) Informant
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 23/48 (month) (day) (year)
(c) Cemetery or crematory: Highland
Location: Street Md.

18 (a) Funeral director: Hubert P Forbair
(b) Address: Delta Pa

19 (a) SEP 20 1948 (Date rec'd by registrar) Huntington Millers Mills Registrar

MEDICAL CERTIFICATION

25A

20. DATE OF DEATH Sept. 20 1948, at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3 1948, to 9/20 1948 and that I last saw her alive on 9/20 1948

Immediate cause of death: Giant follicular lymphoblastoma — Duration: 8 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: John B Hell M. D.

Address

Date signed Sept 20, 48

PLEASE WRITE PLAINLY, with unfading ink. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

666957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

110a

Registered No. 666957

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkens Ave

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2044 Deering ave (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mr John Wilson

3 (b) If veteran, name war None

3 (c) Social Security Account No. 214-03-5465

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ethel Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/9/1907

8. AGE: Years 41 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Md (Town, county, and State)

10. Usual Occupation Chemical Operator

11. Industry or business Paint Chemical

FATHER 12. Name John Wilson

13. Birthplace Penna

MOTHER 14. Maiden Name Sadie Shelton

15. Birthplace Penna

16 (a) Informant Ethel May Wilson

(b) Address 2044 Deering Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Baltimore, Md

18 (a) Funeral director George L. Schwab

(b) Address 2101 Frederick Ave

19 (a) SEP 21 1948 (Date received by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1948 at 9:24 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/2 1948 to 9/19 1948 and that I last saw him alive on 9/19 1948

Immediate cause of death Cardio-Resp Failure

Duration

Due to Overwhelming Uremia

Due to Mixed infection Pleural Empyema Rt

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Sydney J. Yaskell MD

Address St. Agnes Hospital Date signed 9-19-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

66958 Registered No.

PLEASE FILL IN ALL ITEMS. Any false statement, omission or concealment of facts called for herein may result in a fine of not more than $100.00 or imprisonment not exceeding 6 months, or both. Information should be carefully compiled and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County W
(c) City or town Webster Springs (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Holcomb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-15-92

8. AGE: Years 56 | Months 1 | Days 5 | If less than one day: hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Samuel Dodrill
13. Birthplace W. Va.

MOTHER
14. Maiden Name Isabel Skidmore
15. Birthplace W. Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Wetherspring W. Virginia

18 (a) Funeral director Harry H. Wiltse
(b) Address 4104 Edmondson Ave.

19 SEP 21 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1948, at 9 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19 1948 to 9/20 1948 and that I last saw h[illegible] alive on 9/20 1948

Immediate cause of death: GLIOBLASTOMA, RT. FRONTAL LOBE AND CORPUS CALLOSUM — Duration: 6 MOS.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation SEPT. 19, 1948

Major findings of operation: GLIOBLASTOMA RT. FRONTAL LOBE

of autopsy: GLIOBLASTOMA

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Robert E. Green M D
Address Johns Hopkins Hosp. Date signed Sept 20 1948

VS 169

666959

BALTIMORE CITY HEALTH DEPARTMENT "MEDICAL EXAMINER CASE"

CERTIFICATE OF DEATH

47c

Registered No. 666959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 E. Monument Street
(c) Hospital or institution: Sinai Hospital of Baltimore, Inc. 15
(d) Length of stay in hospital or inst. (~~If not in hospital, how long in city~~) days 16
(e) Length of stay in Baltimore (yrs., mos., or days) ——

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4127 Norfolk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Katz - 4127 Norfolk Avenue #16

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ada
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Newfork NY (town, county, and state)
10. Usual Occupation Cab Driver
11. Industry or business

FATHER
12. Name Max
13. Birthplace Russia

MOTHER
14. Maiden Name Celia
15. Birthplace Russia

16 (a) Informant Ada Katz
(b) Address 4127 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-48 (month) (day) (year)
(c) Cemetery or crematory Brooklyn N.Y.
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20th 1948, at 2.15PM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/4/48 19 to 9/20/48 19, and that I last saw h in alive on 9/20/48 19

Immediate cause of death Hemotherax and Tension Pneumotherax, Right — Duration
Due to Bronchogenic Carcinoma right, with spread into Pulmonary vein, Esophagus and Local
Due to Nodes.

Other Conditions Possible Gravits Tumor, Right.
(Include pregnancy within 3 months of death)
Date of operation 9/20/48
Major findings of operation: Inoperable Carcinoma, Right Lung.
of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allan A. Moore M.D.
Address [illegible] Date signed 9/20/48

VS 150

Patient died just after he was removed from the Operating Table
Approved 9/20/48 - C.H. Smith M.D.

666960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 N. Brice St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 N. Brice St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM M. GIBSON, Sr.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1893

8. AGE: Years 55 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Alexandria, Va. (Town, county, and state)
10. Usual Occupation Lead Mold
11. Industry or business National Lead Co.

FATHER
12. Name (Unknown) Gibson
13. Birthplace Va

MOTHER
14. Maiden Name Adalaide (Unknown)
15 Birthplace Va

16 (a) Informant George Gibson, Jr
(b) Address 1318 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

SEP 21 1948 (Date received by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20th 1948 at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1947 to 9-20 1948, and that I last saw h[im] alive on 9-18 1948.

Immediate cause of death: Carcinoma of Pancreas — Duration 1 day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich Jr.
Address 1227 Linden Blvd Date signed 9/20/48 M.D.

VS 150

666961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Try to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2700 Hamilton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Hamilton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA E. HAMILTON

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: L.H.Hamilton
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Aug.18,1861

8. AGE: Years 87 | Months 1 | Days 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Howard Wooten
13. Birthplace

MOTHER
14. Maiden Name Emily Muir
15 Birthplace

16 (a) Informant Charles R. Hamilton
(b) Address 1907 E. Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1948 19 at 11:30 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Sept 1948 to 19 Sept 1948 and that I last saw her alive on Sept 19 1948

	Duration
Immediate cause of death: Hemorrhage Cerebral	24 hrs
Due to Arterio-sclerosis cerebral	15 yrs
Due to Hypertension Vascular	15 yrs
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Sina M.D.
Address 2074 E Belvedere Ave Date signed 9/24/48

VS 150

66962 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 66962

CERTIFICATE OF DEATH

1200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2048 Bank St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME ALFRED W. WOODWARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Gertrude Slowikowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1923

8. AGE: Years	Months	Days	If less than one day
25	5	-	hr. min.

9. Birthplace Westminster, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Western Electric Co.

FATHER
12. Name Milton Woodward
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Gertrude Woodward - wife
(b) Address 2450 E. Eager Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Baltimore National
Location Frederick Ave., Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) SEP 21 1948 (Date received by Registrar) (b) Curtis Bay Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19, 1948, at 3:05 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Dilatation - Enteritis -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Ryan M.D. (Medical Examiner)

Date signed 9/20/48

VS 151

666963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Pennsylvania Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE HUTCHENSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 47 | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Lee Houchens
13. Birthplace Va

MOTHER
14. Maiden Name unknown
15. Birthplace Va

16 (a) Informant Rosa Houche
(b) Address 1000 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/48 (month) (day) (year)
(c) Cemetery or crematory Loudon
Location Loudon Co Va

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna Ave

SEP 21 1948 (Date received by registrar) (b) Washington, D.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1948, at 10 A.M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: [illegible] X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema due to acute congestive cardiac failure

Due to

Other Conditions Chronic alcoholism
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in factory, in store, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royster M.D
Date signed 9-20-48 Medical Examiner

VS 151

111c

66964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

66964
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland
(b) County
(c) City or town Baltimore
(d) Street No. 3502 Powhatan Ave
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W Perkins

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Beulah H. Perkins

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1874

8. AGE: Years: 74 | Months: 0 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Chestertown, Md. (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business:

FATHER
12. Name: Eben F. Perkins
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Mary E. Warwick
15. Birthplace: Phila.

16 (a) Informant: Mrs. Anna Perkins Cook
(b) Address: 820 Roanoke Ave., Elizabeth, N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/22/48
(c) Cemetery or crematory
Location: Chestertown, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19. Date received by registrar: SEP 21 1948

[redacted]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/20/48 19 , at 1155A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

22. If an external cause was primary ☐ cause or contributory ☐ cause of death, fill in the following:
(a) Date of injury: M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place?
(d) Means of injury:

23. Signature: John R Davis M.D.
Medical Examiner
Date signed: 9/20/48

66965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1178

66965 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland St. and Baynes Ave
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Franklin Higinbothom

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Helen D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24th 1884

8. AGE: Years	Months	Days	If less than one day: hr.	min.
64	3	27		

9. Birthplace New York State (Town, county, and state)
10. Usual Occupation machinist
11. Industry or business B & O R.R.

FATHER
12. Name John B. Higinbothom
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Susan B. Harvey
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Helen D. Higinbothom
(b) Address 2502 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson & Longwood Sts.

18 (a) Funeral director John J. Curran & Son
(b) Address 901-03 W. Hollins St.

19 (a) SEP 21 1948 (Date rec'd by local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20th 1948, at 3:55 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 5th 1948, to Sept 20 1948, and that I last saw him alive on Sept 20 1948.

	Duration
Immediate cause of death Cardio-respiratory failure	
Due to Chronic pneumonia (2)	
Due to Hypertensive arterio-sclerotic cardiovascular disease	
Other Conditions Diverticulosis	

(Include pregnancy within 3 months of death)

Date of operation Sept. 16 1948
Major findings of operation: Duodenal ulcer & pancreatic adenoma
Autopsy: Autopsy refused

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

*23. Signature Katharine V. Kemp M. D.
Address West Balto Gen. Hosp. Date signed Sept. 20 1948

VS 150

666966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Mem. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2 USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Beech Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Redmond

3 (b) If veteran, name war: 2

3 (c) Social Security Account No. 219-10-5059

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26-1925

8. AGE: Years	Months	Days	If less than one day
23	3	24	hr. min.

9. Birthplace Baltimore City (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John T Redmon
13. Birthplace Baltimore

MOTHER
14. Maiden Name Clifton
15. Birthplace Talbot Co Md

16 (a) Informant: John T Redmon
(b) Address 3306 Beech Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22-48
(c) Cemetery or crematory Lorraine
Location Baltimore Md

18 (a) Funeral director Frank T Sehl
(b) Address 814 W 36 St

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1948 at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushed Chest
Cerebral Hemorrhage
Due to Multiple Fractures

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept 19 1948 at 3:30 P.M.
(b) Where did injury occur? Hanford Rd. 900 ft S. Harford
(c) Did injury occur at home, on farm, industrial place, or public place? Public (Whether at work)
(d) Means of injury Motor Vehicle Accident

23. Signature [signature] M.D.
Medical Examiner.
Date signed 9-19-48

VS 151

G66967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No. G66967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3710 Chesholm Road
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Chesholm Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna Norah Leonard Kent

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward S. Kent
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1875

8. AGE: Years 72 | Months 8 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name Edmond T. Leonard
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Matilda Larrimore
15. Birthplace Md.

16 (a) Informant Edward S. Kent
(b) Address 3710 Chesholm Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Co., Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION 7.15

20. DATE OF DEATH Sept. 18, 1948, at p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1947 to Sept 18 1948, and that I last saw h alive on Sept 18 1948.

Immediate cause of death Ruptured Aneurysm of The Aorta — Duration

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 3025 W North Ave Date signed 5/20/49

VS 150

66968 ✓ 46D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66968

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3115 Belmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie G. House

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband: Clifford F. House

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 28, 1874

8. AGE: Years 73 | Months 8 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Patrick B. McManus
13. Birthplace Ireland

MOTHER — 14. Maiden Name Mary Ann Hanley
15. Birthplace Ireland

16 (a) Informant Samuel M. House
(b) Address 3115 Belmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23 1948 (month) (day) (year)
(c) Cemetery or crematory Laurel Ridge
Location Pikesville Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave

19 (a) SEP 21 1948 (Date rec'd by registrar) Registrar for Baltimore

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 1948 at 2:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15/48 19 to 9/20 19 48. and that I last saw her alive on 9/20 19 48

Immediate cause of death: Myocardial Failure
Due to: Carcinoma of Rectum
Due to:
Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation September 18, 1948
Major findings of operation: Ca of Rectum
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Faraone M.D.
Address Md. Gen. Hosp Date signed 9/20/48

X

G66969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. G66969

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Caton & Wilkins Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 10
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Anne Arundel
(c) City or town: Curtis Bay (If outside city or town limits, write RURAL and give town)
(d) Street No.: Greenland Beach (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: John Todd
3 (b) If veteran, name war:
3 (c) Social Security Account No.: 212-05-4407

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife: Ethel Todd
6 (c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): 6/26/88

8. AGE: Years	Months	Days	If less than one day
60	2	18	hr. min.

9. Birthplace: Maryland (town, county, and state)
10. Usual Occupation: Retired
11. Industry or business:

FATHER 12. Name	John Edward
FATHER 13. Birthplace	Md.
MOTHER 14. Maiden Name	Elizabeth Taylor
MOTHER 15. Birthplace	Md.

16 (a) Informant: Mrs. Ethel Todd
(b) Address: Greenland Beach, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-48 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Annapolis Blvd

18 (a) Funeral director: John F. Denny Inc.
(b) Address: 760 Light St.

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Curtis Bay, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/18 1948, at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8 1948 to 9/18 1948, and that I last saw him alive on 9/18 1948.

Immediate cause of death: Cardiac Failure — Duration:

Due to: Carcinoma of Bladder with metastasis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: —

of autopsy: — None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Stephen N. Padussis M. D.
Address: St. Agnes Hosp. Date signed: 9/18/48

VS 50

666970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 666970

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1734 Montpelier St.

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 1734 Montpelier St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME: AMELIA M. AMOS

3 (b) If veteran, name war: no

3 (c) Social Security Account No. no

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Walter S. Amos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1882

8. AGE: Years 66 | Months 6 | Days 24 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER

12. Name: Frederick W. Brockman

13. Birthplace: Baltimore, Md.

MOTHER

14. Maiden Name: Christine H. Lauterbach

15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Walter S. Amos

(b) Address: 1734 Montpelier St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) Sept 21 1948 (Received by registrar) (b) [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 19, 1948, at 11.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-48 to 9-19-48; and that I last saw h alive on 9-19-48

Immediate cause of death: Myocardial insufficiency — Duration: 4 days

Due to: Cerebral hemorrhage — 9 mos +

Due to: arteriosclerosis and hypertension — 9 mos +

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [signature]

Address 1517 E. Northrop Date signed 9/20/48

666971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 666971

164a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2716 Harlem Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH BALZER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-03-4485

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Catherine T. Balzer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1889

8. AGE: Years 58 | Months 9 | Days 8 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Pressman

11. Industry or business Baltimore American

FATHER
12. Name Bernard Balzer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Droudy
15. Birthplace Germany

16 (a) Informant: Mrs. Catherine T. Balzer
(b) Address 2716 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month, day, year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 251

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1948 at 9:30AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Strangulation by hanging

Other Conditions Mental despondency over

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-20-48 at A. M.
(b) Where did injury occur? 2715 Harlem Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanging - hung self with (rafter—cellar) electric cord

23. Signature Earl L. Page M.D.
Medical Examiner.
Date signed 9-20-48

G66972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G66972

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2309 Arunah Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2309 Arunah Aye. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FERDINAND M. ARNREICH

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Augusta J. Arnreich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1865

8. AGE: Years 82 | Months 9 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Wholesale Fish Business

11. Industry or business Retired

FATHER

12. Name John H. Arnreich

13. Birthplace Germany

MOTHER

14. Maiden Name Louisa Rudolph

15. Birthplace Germany

16 (a) Informant Mrs. Louisa D. Wells

(b) Address 2309 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.

Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

19 SEP 21 1948 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1948 at 9:05 M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 2 1948 to Sept 18 1948 and that I last saw h alive on Sept 18 - 48

Immediate cause of death — Duration

Due to Hy pertension

Due to Cardio vascular Dis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)

(e) Means of injury

23. Signature Thomas S. Frank M.D.

Address 2329 Arunah Ave Date signed 9/21/48

VS 150

G66973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66973

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physician: please write the causes of death clearly and legibly.

BLANK RESERVED FOR READING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2023 Eastern ave
(c) Hospital or institution:

2-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 Eastern ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jan Lubawski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Antonina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
about 68			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Antonina Lubawski
(b) Address 2023 Eastern ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) SEP 21 1948 (Date rec'd by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1948 at 12 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from FEB. 2 1946 to SEPT. 19 1948 and that I last saw h. l. alive on SEPT 19 1948.

Immediate cause of death ARTERIO SCLEROTIC CARDIO-VASCULAR RENAL DISEASE — Duration 2/2/46

Due to

Due to

Other Conditions CHRONIC BRONCHITIS ???

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 289 [illegible] Date signed 9/20/48

VS 150

X

G66974

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G66974

BC - 48-19923 CERTIFICATE OF DEATH 160a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution: Sinai Hospital 15-12
(d) Length of stay in hospital or inst: (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3722 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Girl Egorin
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19, 1948

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Sinai Hospital, Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Theodore Egorin
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Naomi Mervis
15. Birthplace Baltimore, Md.

16 (a) Informant Mother- Mrs. Naomi Egorin
(b) Address 3722 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 21 48 (month) (day) (year)
(c) Cemetery or crematory Arabei Emunah Cem
Location Washington Blvd.

18 (a) Funeral director Sol Funeral Home
(b) Address 1124-26 W North Ave.

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Huntington [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20, 1948 at 9:30 am

21. I certify that death occurred on the date above stated; that I attended deceased from 19 September 1948, to 20 September 1948 and that I last saw her alive on 20 September 1948

Immediate cause of death: subarachnoid hemorrhage — Duration: 1 day

Due to birth injury

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged if multiple.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William V. Brown, Jr. M. D.
Address Sinai Hospital Date signed 21 Sept.

666975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

666975 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave
(c) Hospital or institution: Bar-Wil-Ba Home 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 N. Bruce Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Kellum

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-0955

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Widowed
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Furniture Mover
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. E. Williams
(b) Address 1317 Madison Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22-1948 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City

18 (a) Funeral director Joseph A. Lowly
(b) Address 6 West Lanvale Street

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Huntingtown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18, 1948 at 9:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 19 48 to 9/18 19 48, and that I last saw h[illegible] alive on 9/17 19 48.

Immediate cause of death Coma Uremia Renal Disease, Complicated Bronchial Pneumonia — Duration 2 years Stage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Jackson M. D.
Address 608 Mallory Bldg Date signed 9/21/48

H. L. Jackson

VS 150

G66976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9-D

Registered No. G66976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5127 Bertram Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert Kuntzman
3 (b) If veteran, name war
3 (c) Social Security Account No. 214-01-4239

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mildred Kuntzman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 25, 1904

8. AGE: Years	Months	Days	If less than one day: hr.	min.
43	11	26	25	

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Bus Mechanic
11. Industry or business Balto Transit C.

FATHER
12. Name Augustus Kuntzman
13. Birthplace Md.

MOTHER
14. Maiden Name Theresa Hunt
15. Birthplace Md.

16 (a) Informant Mrs. Mildred Kuntzman
(b) Address 5927 Bertram Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore
18 (a) Funeral director J. J. Ruck
(b) Address 5305 Harford Rd.
19 (a) SEP 21 1948 (Date received by Registrar) (b) Huntington Williams M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20/48 19 at 2:25 A.M
21. I certify that death occurred on the date above stated; that I attended deceased from 11/6/48 19 to 11/20/48 19 and that I last saw him alive on 11/20/48 19

Immediate cause of death: Bronchopneumonia
Due to Cardiac decompensation
Due to Hypertension in Cardiovascular Disease
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William T. Hamm, M.D. M. D.
Address South Balto Gen Hosp Baltimore 30, Md. Date signed 9/20/48

G66977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66977

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 Glenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Glenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patrick J. Thornton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Katherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17-1873

8. AGE: Years 74 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace County Louth, Ireland (Town, county, and State)
10. Usual Occupation Retired
11. Industry or business

FATHER: 12. Name Patrick Thornton
13. Birthplace Ireland

MOTHER: 14. Maiden Name Bridget Morgan
15. Birthplace Ireland

16 (a) Informant Mrs. Katherine Thornton
(b) Address 709 Glenwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto

18 (a) Funeral director J. J. Luck
(b) Address 5305 Ridgewood Ave

19 (a) SEP 21 1948 (Date rec'd by Registrar) Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Sept. 1948, at 7.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Sept. 1948 to 20 Sept. 1948, and that I last saw him alive on 20 Sept. 1948.

Immediate cause of death: Arteriosclerotic Cardio-Vascular Disease — Duration 5 yrs.
Due to
Due to
Other Conditions Cerebral Sclerosis with senile psychosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Kammer Jr.
Address 501 Sheridan Ave. Date signed 21 Sept. 48

VS 150

666978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 666978

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3711 Clipper Road.
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Clipper Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Barnes.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-5908

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John H. Barnes.
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) June 22, 1895

8. AGE: Years	Months	Days	If less than one day
53	2	27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Office Clerk.
11. Industry or business Cotton Duck Mill.

FATHER
12. Name Henry J. Schmid.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary E. LeBon.
15. Birthplace Baltimore Md.

16 (a) Informant John H. Barnes (Husband)
(b) Address 3711 Clipper Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-48. (month) (day) (year)
(c) Cemetery or crematory Prospect
Location Near Glenburn Carroll Co. Md.

18 (a) Funeral director Walter P. McNamara
(b) Address 4104 Falls Road

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1948 to Sept 19 1948. and that I last saw h[illegible] alive on Sept 19 1948.

Immediate cause of death: Carcinoma Breast with metastases — Duration: 3 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 371[illegible] Falls Rd Date signed 9-[illegible]-48

VS 150

666979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

666979 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 LIGHT ST
(c) Hospital or institution: — 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 LIGHT ST (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN LANG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife ANGELA E MILLER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/4/1907

8. AGE: Years 41 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation BARBER

11. Industry or business

FATHER
12. Name JOSEPH LANG
13. Birthplace AUSTRIA

MOTHER
14. Maiden Name ELIZ. GRIESS
15. Birthplace HUNGARY

16 (a) Informant MRS JOHN LANG
(b) Address 1312 LIGHT ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway

18 (a) Funeral director Dilatush Bros
(b) Address 818 Light St.

19 SEP 21 1948 (Date filed by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 18 1948 at 5 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 1, 1948 to SEPT 18 1948, and that I last saw H M alive on SEPT 18 1948.

	Duration
Immediate cause of death HYPERTENSIVE CARDIO-VASCULAR	
Due to DISEASE	
Due to	
Other Conditions ARTERIOLAR NEPHROSCLEROSIS (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Hourahan M.D.
Address 333 S. Ellwood Ave. Date signed 9-21-48

VS 150

927

66980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 66980

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2211 W. Rogers Ave

(c) Hospital or institution: Home for the Aged of the Methodist Church of Balto City

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yrs 2 mos 22 days

(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2211 W. Rogers Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ETTA JANE REESE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Vernon Reese

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 7, 1871

8. AGE: Years	Months	Days	If less than one day
77	7	12	hr. min.

9. Birthplace Near Westminster Carroll Co. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm. Henry Caple

13. Birthplace Carroll Co. Md

MOTHER 14. Maiden Name Margaret Ann Woolery

15. Birthplace Carroll Co. Md.

16 (a) Informant (Mrs. D.L.) Mary W. Ennis

(b) Address 2211 W. Rogers Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)

(c) Cemetery or crematory WESTMINSTER

Location WESTMINSTER MD

18 (a) Funeral director Reese's

(b) Address Westminster Md.

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1948, at 11.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1947 to Sept 19 1948 and that I last saw h[illegible] alive on Sept 19 1948

Immediate cause of death Coronary occlusion — Duration 3 days

Due to Cardio-vascular disease — ?

Due to

Other Conditions Abdominal hernia (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles L. Warner M. D.

Address 424 Med. Arts Bldg. Balto 1, Md. Date signed 9/[illegible]/48

VS 150

G66981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. G66981

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 311 E. 30th street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 E. 30th street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA C. SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife William J. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 10, 1859

8. AGE: Years	Months	Days	If less than one day
89	5	9	hr. min.

9. Birthplace County Clare, Ireland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Patrick Coffey
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Grace Smith
(b) Address 311 E. 30th street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J. Evans & Son
(b) Address 117 W. Mt. Royal Ave.

19 (a) SEP 21 19[illegible] (Date rec'd by registrar) (b) Huntington [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 19 48 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 19 45 to Sept 19 1948 and that I last saw her alive on Sept 17 19 48

Immediate cause of death Generalized Arteriosclerosis — Duration Indefinite
Due to —
Due to —
Other Conditions Hypostatic pneumonia — Indefinite
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Nathaniel M Beck M. D.
Address 100 E. 23rd St. Date signed Sept. 19 48

VS 150

BC-48-12718

666982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 666982

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address So. Balto Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 722 S. Bradley Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dolores Heckman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-6-48.

8. AGE: Years | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Floyd Shrewsberry
13. Birthplace Va.

MOTHER
14. Maiden Name Anna C. Peters.
15. Birthplace Md.

16 (a) Informant: family
(b) Address same

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-22-48
(c) Cemetery or crematory Cedar Hill
Location Brooklyn
18 (a) Funeral director James L. McCauley
(b) Address 1362 Fort Ave.

19 (a) SEP 21 1948 Huntington Williams, M.D.
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18/48 19 5:06 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to Aspiration of vomitus

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Kruger M.D.
Medical Examiner
Date signed 19 Sept 48

VS 151

G66983

AB-122594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G66983 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16days
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 22 N. Vincent St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Archie Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9- 1870

8. AGE: Years 78 | Months 4 | Days 8 | If less than one day: hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 21-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn, Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1600 Bentley ave

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Curtis Bay Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17- 1948 at 5.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31- 1948, to 9-17- 1948. and that I last saw him alive on 9-17- 1948

Immediate cause of death: Uremia — Duration: Days ?

Due to: Urinary retention

Due to: Benign Prostatic Hypertrophy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/31/48

Major findings of operation: Urinary retention

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman F. Cole M.D.
Address 4940 Eastern Ave Date signed 9/20/48

VS 150

G66984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66984

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 N. Pine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Pine St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Corbin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	C	Widower

6 (b) Name of husband or wife Mary E. Corbin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1883

8. AGE: Years	Months	Days	If less than one day
65	6	14	hr. min.

9. Birthplace Caroline Co. Va., (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis Corbin
13. Birthplace Caroline Co. Va.,

MOTHER
14. Maiden Name Hardy
15. Birthplace Caroline Co. Va.,

16 (a) Informant Sophia Corbin
(b) Address 222 N. Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 22 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Hattie R. Billups
(b) Address 322 N. Schroeder St.

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18 1948 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1948 to 9/18 1948, and that I last saw h[illegible] alive on 9/12 1948

Immediate cause of death Pneumonia — Duration 2 wks

Due to

Due to

Other Conditions Arteriosclerosis — 5 yrs
Dehydration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Carmen
Address 213 Courtenay Date signed 9/20/48

X

G66985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G66985

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 918 N. Arlington Ave.
(c) Hospital or institution: H-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 N. Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Brown.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife William Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1900.

8. AGE: Years	Months	Days	If less than one day
47	8	25	hr. min.

9. Birthplace Darlington, S.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Stepney Peterkin,
13. Birthplace Darlington, S.C.

MOTHER
14. Maiden Name Sarah Hamilton
15. Birthplace Darlington, S.C.

16 (a) Informant Nora Moses.
(b) Address 503 N. Para...

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 22, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3229 W. Schroeder St.

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Name of Physician or Midwife

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19/48, 19 . at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/31, 1948 to 9/19, 1948
and that I last saw h. alive on 9/19, 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day, 1948
Due to Hypertension	
Due to	

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. T. Gunn M. D.
Address 622 Darlington Ave. Date signed 9/20/48

666986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. 666986

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Harford

(c) City or town Whiteford, Maryland (If outside city or town limits, write RURAL and give town)

(d) Street No. 20 (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret Stump Bull

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Elmer H. Bull

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr) 5/20/75

8. AGE: Years	Months	Days	If less than one day
73	4	1	hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John H. Barrow

13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret Smith

15. Birthplace Maryland

16 (a) Informant

(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Sept 25 1945 (month) (day) (year)

(c) Cemetery or crematory Deer Creek

Location Clair Rd. Kilbert & Perkins

18 (a) Funeral director

(b) Address Huntingdon, Pa

19 (a) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1945 at 7:11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1945 to Sept 21 1945 and that I last saw h alive on Sept 11 1945

Immediate cause of death Carcinomatosis

Due to Carcinoma of gall bladder

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/1/45

Major findings of operation: Carcinoma of gall bladder, Cholelithiasis

If autopsy:

Duration
About 3 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify two) While at work?

(e) Means of injury

23. Signature John A Decker

Address Union Memorial Hosp Date signed 9/22/45 M D

666987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

Registered No. 666987

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22-
(c) Hospital or institution: South Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 0 8 Hanover Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert A. Grimes

3 (b) If veteran, name war: Un
3 (c) Social Security Account No. 217-18-2652

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7 1914

8. AGE: Years 34 | Months 6 5 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Country Man

11. Industry or business

FATHER
12. Name F. J. Grimes
13. Birthplace Maryland

MOTHER
14. Maiden Name Isabella Lemmon
15. Birthplace Maryland

16 (a) Informant Mary L. Grimes
(b) Address 508 Hanover Rd Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 23 48 (month) (day) (year)
(c) Cemetery or crematory Harmony
Location Howard Co Md

18 (a) Funeral director H. Harry Hunt Co
(b) Address Catonsville Md

19 (a) SEP 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 101

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Sept. 1948 at 8:04 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Uno death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammen Jr. M.D. Medical Examiner
Date signed 21 Sept. 48

Medical Examiner Case

066988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 066988

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 110 N. Calhoun St.

(c) Hospital or institution: Franklin Square Hosp.

(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 13 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Raspburg, Md (If outside city or town limits, write RURAL and give town)

(d) Street No. Clayton Ave (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Joseph Maxwell Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-9501

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Lyda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 10 1885

8. AGE: Years	Months	Days	If less than one day
63	6	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Blacksmith, Retired

11. Industry or business

FATHER 12. Name Thomas Maxwell

13. Birthplace England

MOTHER 14. Maiden Name (Unknown) Morgan

15. Birthplace Baltimore, Md.

16 (a) Informant Joseph Maxwell Jr.

(b) Address Clayton Ave., Raspburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc.

(b) Address 1217 St. Paul St.

19 (a) SEP 21 1948 (Date received by registrar) (b) Huntington Williamsburg, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1948 at 4:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1948 to Sept 21 1948, and that I last saw him alive on Sept 21 1948

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Bobby L. Jones M. D.

Address Franklin Sq. Hosp. Date signed 9/24/48

Certificate filed & Vital Statistics Register by Howard D. Madden, M. D.

G66989 42-18262 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G66989

CERTIFICATE OF DEATH 119a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 30 (If outside city or town limits, write RURAL and give town)
(d) Street No. 35 E Burkehead St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LINDA LEE BEAVERS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced unmd

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 6, 1946

8. AGE: Years | Months | Days 15 12 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Frank M. Beavers
13. Birthplace Elkins W. Va

MOTHER 14. Maiden Name Agnes M. Floyd
15. Birthplace Balto Md

16 (a) Informant Frank M. Beavers
(b) Address 35 E Burkehead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto Co

18 (a) Funeral director C. C. Homer (Evans)
(b) Address 1400 St Paul St

SEP 21 1946 (Date received) (b) [illegible] Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1946 at 3 55 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-15 1946 to 9-21 1946.
and that I last saw her alive on 9-21 1946.

Immediate cause of death Uremia
Acidosis — Duration 3 days

Due to Dehydration — 3 days
Due to Toxic Diarrhea — 10 days

Due to Manilla Albegans
Infection (Thrush) — 10 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward A. Powell M. D.
Address 1213 Light Street Date signed 9-21-46

666990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 666990

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lenai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2236 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Flora Kennen (KERNAN)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John Kernan (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) March 20, 1891
8. AGE: Years 57 | Months 6 | Days - | If less than one day: hr. min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Enton Garcia
13. Birthplace: Spain

MOTHER
14. Maiden Name: Mary Love
15. Birthplace: Baltimore

16 (a) Informant: John Kernan
(b) Address: 2236 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23/48 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Baltimore Md

18 (a) Funeral director: Lynch & Lynch
(b) Address: 900 N. Eutaw St

19 SEP 21 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1948, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11-48 1948, to 9-20 1948, and that I last saw her alive on 9-20 1948.

Immediate cause of death: Cardiac failure — Duration
Due to: Coronary Thrombosis
Due to:
Other Conditions: Hypertension, Diabetes mellitus
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Jerome Gaber M. D.
Address: Sinai Hosp. Date signed 9-20-48

94a

VS 150

(666991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51

Registered No. 666991

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: 17
Not Admitted
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days In Acc Rm.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 N. Pine (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Levin De Shields

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day hr.	min.
62	—	—		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Labor —
11. Industry or business

FATHER
12. Name Nathan De Shields
13. Birthplace Cambridge Md.

MOTHER
14. Maiden Name Margaret Chase
15. Birthplace Cambridge Md.

16 (a) Informant Filmore Thomas
(b) Address 30 W. Cross St.

17 (a) (Burial, cremation, or removal) (b) Date thereof Sept 22-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Baltimore

18 (a) Funeral director Walter B. Jones
(b) Address 138 W. Lanvale Street

19 SEP 21 1948 (b) Registrar
(Date rec'd by Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8- 1948 to 9-19 1948 and that I last saw him alive on 9-19 1948.

Immediate cause of death cardiorespiratory failure (CARDIO RESPIRATORY)

Due to ascites, etiology probably from metastatic cancer penis.

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature John L. Rossen M. D.
Address University Hospt Date signed 9-19-48

666992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. 666992

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 216 N. Milton Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 216 N. Milton Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH E. MISTER

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Albert T

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 20, 1876

8. AGE: Years: 71 | Months: 10 | Days: - | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER

12. Name: J. Ha daway

13. Birthplace: Md

MOTHER

14. Maiden Name: Emma Haddaway

15. Birthplace: Md

16 (a) Informant: Mrs Frances Lowenthal

(b) Address: 216 N. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)

(c) Cemetery or crematory: Tilghman Methodist

Location: Tilghman Island, Md.

18 (a) Funeral director: William Cook, Inc

(b) Address: 1217 St. Paul St.

19 (a) SEP 21 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1948, at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 19 48 to Sept 20 19 48, and that I last saw her alive on 9/19/48 19

Immediate cause of death: Carcinoma of Pancreas — Duration: 1 yr

Due to:

Due to:

Other Conditions: Diabetes — Long

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury:

23. Signature: J. B. Lowe Lowe M.D.

Address: 1901 Eutaw Place, City Date signed 9/20/48

G66993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G66993

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3810 Fear Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Fear Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN BLAKE

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	~~Widowed~~ Divorced

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1872

8. AGE: Years	Months	Days	If less than one day
76	5	10	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Landscape Gardner Retired
11. Industry or business

FATHER
12. Name John Blake
13. Birthplace Md

MOTHER
14. Maiden Name Martha O'Donnell
15. Birthplace Md

16 (a) Informant Walter Blake
(b) Address 4015 W. Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)
(c) Cemetery or crematory St. Ignatus Hickory
Location Harford County, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) Date received by Registrar SEP 21 1948 (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1948 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Sept 15 1948, and that I last saw him alive on Sept 15 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerotic Heart Disease	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Manuel Levin M. D.
Address 4 E. Redwood St. Date signed 9/21/48

VS 150

X

G66994 A 64453

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G66994 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince George
(c) City or town Upper Marlboro (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Doris Harmon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7-24-~~26~~ 37

8. AGE: Years ~~12~~ 11 | Months 1 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Harmon
13. Birthplace Va.

MOTHER
14. Maiden Name Ruth Jones
15. Birthplace Penn.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Cedarville
Location Cedarville, Md.

18 (a) Funeral director Ritchie Bros.
(b) Address Upper Marlboro, Md.

19 SEP 22 1943 (Date rec'd by registrar) Huntington Williams, M.D.

(Information supplied by Ritchie Brothers Funeral Home, Marlboro, Md.)

MEDICAL CERTIFICATION 48 55A

20. DATE OF DEATH Sept. 21 1941, at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/27 1948 to 9/21 1948, and that I last saw her alive on 9/21 1948.

Immediate cause of death: Candiac failure — Duration

Due to acute rheumatic carditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Furey M. D.
Address Johns Hopkins Hosp Date signed 21 Sept 48

066995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

73

Registered No. 066995

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2301 Aiken Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2301 Aiken Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ABBIE LOUELLA BAY

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elmer Ross Bay

6 (c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): January 20, 1873

8. AGE: Years: 75 Months: 8 Days: 0 If less than one day: hr. min.

9. Birthplace: Harford County, Md. (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: Wilson Wallace
13. Birthplace: Harford Co., Md.

MOTHER
14. Maiden Name: Louisa Howlett
15. Birthplace: Harford Co., Md.

16 (a) Informant: Mrs. Ross Bay
(b) Address: 2301 Aiken Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)
(c) Cemetery or crematory: Slate Ridge Cemetery
Location: Delta, Pa.

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1948 7.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1947 to Sept 1948.
and that I last saw h[illegible] alive on 20 Sept 1948.

Immediate cause of death: Secondary Anemia — Duration: 1 yr

Due to: Irremovable Pessary — Duration: 2 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed [illegible] M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. 66996

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1716 E. Lafayette Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 E. Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ERMINDO G. BARSOTTI

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 219-01-6672

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha I. Barsotti
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1880

8. AGE: Years 67 | Months 11 | Days 11 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Giovanni Barsotti
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Cirillo
15. Birthplace Italy

16 (a) Informant Mrs Bertha I. Barsotti
(b) Address 1716 E. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Sept. 19 48, at 8.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7th. 19 48 to Sept. 19th. 19 48.
and that I last saw him alive on Sept. 18th 19 48.

Immediate cause of death	Duration
Acute Cardiac Dilitation	immediate
Due to Myocarditis & Endocarditis	unknown
Due to ----------	
Other Conditions Chronic Bronchitis	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury GEO. W. HURGATHOYD

23. Signature Geo. W. Hurgathoyd M.D.
Address 401 E. 25th. St. Date signed 9/21/48. M D

VS 150

666997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 666997

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2040 N. Washington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2040 N. Washington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES WILLARD TUCKER

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lottie Elizabeth

6 (c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): August 24, 1867

8. AGE: Years: 81 Months: 0 Days: 27 If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Penna. R.R.

11. Industry or business: retired

FATHER
12. Name: John Tucker
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Mary Perkins
15. Birthplace: Virginia

16 (a) Informant: Mrs. Lottie E. Tucker
(b) Address: 2040 N. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/ /48 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH: September 20, 19 48 at 12.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1948 to Sept 20 1948 and that I last saw h[illegible] alive on Sept 18 1948.

Immediate cause of death: Carcinomatosis — Duration: Aug 1/45
Carcinoma of Stomach
Due to Pyloric Ob. ?
abdominal fluid removed also
Due to
Other Conditions arterio-sclerosis —

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature [illegible] M. D.
Address 722 N Kenwood Ave Date signed Sept

G66998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G66998

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 213 Light St

(c) Hospital or institution: So. Balto. Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 9 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4303 Nicholas Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: KATHERINE WEDRA

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife: George Wedra

6 (c) If alive, give age: 67 years

7. Birth date of deceased: mo., day, yr: May 15, 1883

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65	4	4		

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER

12. Name: Gottleib Dittman

13. Birthplace: Germany

MOTHER

14. Maiden Name: Mary Coonig

15. Birthplace: Germany

16 (a) Informant: Mr. George Wedra

(b) Address: 4303 Nicholas Avenue - B

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)

(c) Cemetery or crematory: Moreland Memorial Cemetery

Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC

(b) Address: NORTH AVE. & BROADWAY

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1948 at 10 50 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from June 10 1948 to Sept 19 1948, and that I last saw h[illegible] alive on Sept. 19 1948.

Immediate cause of death: Gangrene right foot — Duration: 3 mos 23 days

Due to: Arteriosclerosis

Due to:

Other Conditions: Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy: none performed

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: W. C. Dooley, Jr. M.D.

Address: 213 Light St. Date signed 9-19-48

97

666999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

666999 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3571 Fourth St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)

(d) Street No. 3571 Fourth St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William F. Conway

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sallie (Sarah) Slaughter

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Feb 13, 1877

8. AGE: Years 71 | Months 7 | Days 5 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Railroad

FATHER

12. Name Anthony Conway

13. Birthplace Md

MOTHER

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Mrs Sarah Conway

(b) Address 103 E. Randall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 (month) 22 (day) 48 (year)

(c) Cemetery or crematory London Park

Location Frederick Co.

18 (a) Funeral director John F Denny Inc

(b) Address 515 Light St.

19 (a) SEP 22 1948 (Date received by Registrar) (b) Edgington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1948 at 7 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to Sept 18 1948; and that I last saw him alive on 9-18 1948.

	Duration
Immediate cause of death: Diabetes	3 mo.
Due to: Cerebral Hemorrhage	
Due to: Coronary Sclerosis	
Other Conditions: Coronary occlusion & Hypertension	10 da

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Fred Ruzicka M.D.

Address 109 N Gilmore Baltimore Date signed 9-24-48

VS 150

G67000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82B

Registered No. G67000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 151 N Poplar Grove St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-9

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)

(d) Street No. 151 N Poplar Grove St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph F. McKEWEN

3 (b) Veteran, name war None

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife ADELINE McKEWEN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 19-1884

8. AGE: Years 64 | Months 6 | Days 7 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business Unknown

FATHER: 12. Name

13. Birthplace

MOTHER: 14. Maiden Name

15. Birthplace

16 (a) Informant MARGARET G. SWEENEY

(b) Address 151 N Poplar Grove St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Sept 13-48 (month) (day) (year)

(c) Cemetery or crematory NEW CATHEDRAL

Location Baltimore Md

18 (a) Funeral director Patt & B.M. Walters

(b) Address Patt & Stricker $ts

19 SEP 22 1948 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1948 at 4 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9 [illegible] 19[illegible] to 9 [illegible] 19[illegible], and that I last saw h[illegible] alive on 9 [illegible] 19[illegible].

Immediate cause of death Cerebral Thrombosis — Duration 12 hrs

Due to Generalized Atherosclerosis — 4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Sam Feldman M.D. M.D.

Address 101 Eutaw Street Date signed 9-11-48

X

667001

667001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45c

Registered No. 667001

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 882 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN BURNS HATHAWAY

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 28, 1894

8. AGE: Years 54 | Months 3 | Days 22 | If less than one day hr. min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Oiler

11. Industry or business Seafarer

FATHER
12. Name John B. Hathaway
13. Birthplace Texas

MOTHER
14. Maiden Name Lucille Mc Queen
15 Birthplace Texas

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22-48 (month) (day) (year)
(c) Cemetery or crematory Mt Peter's
Location Baltimore & Forman

18 (a) Funeral director Ray B. Robertson Inc
(b) Address 403 E. 25th St

19 (a) SEP 22 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1948 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 1948 to Sept. 19 1948, and that I last saw him alive on Sept. 19 1948.

Immediate cause of death Carcinoma, floor of mouth with extensive metastases to liver — Duration 12 yrs.

Due to (2) Arteriosclerosis moderate — Duration Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 9/20/48

age is especially important. Physicians: please write the causes of death clearly and legibly.

687002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 687002

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 Greenmount Ave.
(c) Hospital or institution: Southern Hospital & Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4808 Harford Road (If rural give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Frank A. Bevans

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1873

8. AGE: Years	Months	Days	If less than one day
75	1	1	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation gardener
11. Industry or business

FATHER
12. Name Joshua A. Bevans
13. Birthplace ?

MOTHER
14. Maiden Name Sophie D. Hederman
15 Birthplace ?

16 (a) Informant Records, Southern Home
(b) Address 2510 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)
(c) Cemetery ~~crematory~~ Lorraine
Location Windsor Mill Road, Baltimore

18 (a) Funeral director John L. Whitelaw & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) SEP 22 1948 (Date rec'd by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1. 1948 to Sept 21 1948, and that I last saw him alive on Sept 20. 1948.

Immediate cause of death — Duration

Due to carcinoma of

Due to stomach

Other Conditions & Cancer

+ age.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home; on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert C. Blake M.D.
Address Medical Arts Bldg. Date signed 9-22-48

VS 130

G67003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G67003

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2025 W. Fayette ST.

(c) Hospital or institution: Bon Secours Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County —

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 201 S. Fremont Rd. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs Myrtle E. Brohawn - Myrtle E. Brohawn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Irving L. Brohawn

6 (c) If alive, give age 52 years

7. Birth date of deceased (month, day, year) June 3 - 1897

8. AGE: Years	Months	Days	If less than one day
51	8	15	— hr. — min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business At Home

FATHER 12. Name John H. Dames

13. Birthplace Baltimore - Md.

MOTHER 14. Maiden Name Gertrude E. Lantz

15. Birthplace Baltimore - Md

16 (a) Informant Irving L. Brohawn

(b) Address 201 - S. Fremont Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 22 Sept. 48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Co. Md

18 (a) Funeral director C. B. Wippert Son

(b) Address 1700 Eutaw Place

19 (a) SEP 22 1948 (Date rec'd by Reg'r) (b) Huntingtown Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1948 at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1948 to 9-18 1948.

and that I last saw her alive on 9-18 1948

Immediate cause of death Cerebro-Vas. Accident — Duration

Due to Hypertension C.V.D

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature George W. Fisher M. D.

Address Bon Secours Hosp Date signed 9-18-48

VS 130

67004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 67004

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen. Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3216 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Howard

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wyatt G Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Oct 8, 1890

6. AGE: Years 57 | Months 11 | Days 13 | If less than one day: hr. min.

9. Birthplace: Boring, Md. (Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business

FATHER
12. Name: John H Pevergay
13. Birthplace: Baltimore County

MOTHER
14. Maiden Name: Elizabeth C. Myers
15. Birthplace: Baltimore County

16 (a) Informant: Mr. Wyatt G. Howard, husband
(b) Address: 3716 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)
(c) Cemetery or crematory: Pleasant Grove Cem.
Location: Balto. Co., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) [signature illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1948 at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1948 to 9/21 1948.
and that I last saw her alive on 9/20 1948

Immediate cause of death: Cardiac Failure - Carcinoma of Breast with metastases — Duration: April 1948

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Frank A. Fraraino M.D.
Address: Md. Gen. Hosp. Date signed 9/21/48

VS 159

G67005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G67005 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1300 Madison Street + Tenideck
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 Grantley Street # 29 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward F Long

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Emma V. Long
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 11, 1886

8. AGE: Years	Months	Days	If less than one day
61	11	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Pullman Conductor

FATHER
12. Name Adolphus J. Long
13. Birthplace N. Y.

MOTHER
14. Maiden Name Annie Cathcart
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Emma V. Long
(b) Address 730 Grantley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) Tuttington-Williams M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1948, at 6:50 A M

21. I certify that death occurred on the date above stated, that I attended deceased from September 1948, to September 1948, and that I last saw him alive on Sept 20 1948

Immediate cause of death Cardiac failure — Duration 6-8 mos

Due to Hypertensive Cardiovascular disease — 10 years

Due to

Other Conditions AURICULAR ANASARCA Anasarca Auricular fibrillation — 1 week

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marguerite Louise Candle M.D.
Address Maryland General Hosp. City Date signed 9/4/48

X

67006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67006

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTIMORE
(c) City or town ESSEX
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 GEORGE AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GUS J. STRATAKIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ANNA STRATAKIS
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr) ?

8. AGE: Years	Months	Days	If less than one day
64?			hr. min.

9. Birthplace GREECE
(Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name JAMES STRATAKIS
13. Birthplace GREECE

MOTHER
14. Maiden Name KATHARINE GUSTOPHALIC
15. Birthplace GREECE

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-48 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Windsor Mill Rd

18 (a) Funeral director Lambros Inc
(b) Address 438-40 E. North ave

19 (a) SEP 22 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 20 1948, at 11 05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3 1948, to 9-20 1948, and that I last saw him alive on 9-20 1948.

Immediate cause of death circulatory collapse — Duration 4 mo.+

Due to carcinomatosis, prob. primary in pancreas

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/20/48

Major findings of operation: carcinoma liver & pancreas

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify one)
(e) Means of injury

23. Signature E. W. Smith M.D.
Address J.H.H. Date signed 9/20/48

VS 150

G67007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

✓ G67007 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4024 Calborne Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4024 Calborne Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Raimondi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Fabbruciano

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1867

8. AGE: Years 81 Months 6 Days 27 If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Silvesta

13. Birthplace Italy

MOTHER 14. Maiden Name Flemma

15. Birthplace Italy

16 (a) Informant Mrs. Vincent J. Tulco

(b) Address 4024 Calborne Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Location 4430 Belair Rd.

18 (a) Funeral director Harry H. Mitchell

(b) Address 401 Edmondson Ave.

19 Sept 22 1948 (Date received by registrar) Hollington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20, 1948, at 12 55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to 9/20 1948, and that I last saw her alive on 9/19 1948.

	Duration
Immediate cause of death Broncho-Pneumonia (Terminal)	9/14/48
Due to Generalized Carcinomatosis	1 yr.
Due to Carcinoma of Liver	2½ Years
Other Conditions Fracture of Neck of Right Femur	9/16/48

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: N/A

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 9/16/48 at 10 PM

(c) Where did injury occur? Balto City Md (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)

(e) Means of injury Fell out of Bed

23. Signature

Address 3629 Edmondson Date signed 9/21/48 M. D.

VS 150

Certified for Dr. Wm. Helfrich by Howard J. Maddux, M.D. 46 F

G67008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G67008 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Aged Women's & Men's Home, 1400 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME MARY BLANCHE TRAUT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 24 1875

8. AGE: Years	Months	Days	If less than one day
72	10	17	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name George L. Stocksdale
13. Birthplace Maryland

MOTHER
14. Maiden Name Keziah Cole
15 Birthplace Maryland

16 (a) Informant Union Mem. Hosp. Record
(b) Address Baltimore Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)
(c) Cemetery or crematory Evangelical Lutheran
Location Shrewsbury Pa.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 SEP 22 1948 (Date received by Registrar) Huntington Williams Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21, 1948, at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 24, 1948. to Sept. 21 1948. and that I last saw her alive on Sept 20 1948.

Immediate cause of death	Duration
Metastatic carcinoma to lymph nodes, liver, kidney, mesentery, intestines (from	
Due to primary site in sigmoid	
Intestinal Obstruction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5-5-48 and 5-14-48

Major findings of operation: Adenocarcinoma of sigmoid colon with metastases

of autopsy: none or short

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn P. Grove, M.D.
Address Union Memorial Hospital Date signed 9/24/48

VS 150

667009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

667009 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison Street and Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 E. 20th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John T. Overby

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-2629

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Gertrude Gerard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8th 1876

8. AGE: Years	Months	Days	If less than one day
71	11	13	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Retired Supervisor

11. Industry or business Hatters Bros

FATHER 12. Name John Overby
13. Birthplace N. C.

MOTHER 14. Maiden Name Sarah Britt
15. Birthplace N. C.

16 (a) Informant Gertrude Overby
(b) Address 722 E. 20th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) SEP 22 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1948 at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1948 to 9-21 1948 and that I last saw him alive on 9-21 1948

Immediate cause of death	Duration
Hypostatic pneumonia	11 days
Due to Cerebro vascular accident	22 days
Due to Arteriosclerotic cardio-Vascular disease	10-12 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marguerite Louise Lamb M. D.

Address Date signed

VS 150

X

G67010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G67010 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 125 S. Conkling St.
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 S. Conkling St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Piniarski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/25/92

8. AGE: Years 55 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

FATHER 12. Name Magnus Brown

13. Birthplace Ger.

MOTHER 14. Maiden Name Mary Wentzel

15. Birthplace Balto

16 (a) Informant Joseph Piniarski

(b) Address 125 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location Leeman Hill Rd

18 (a) Funeral director Gilly & Zeluch

(b) Address 403 S. Eaton St.

19 SEP 22 1948 (Date received by registrar) (b) Huntingtn Williams Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 48 at 12 11 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-1 1948 to 9-20 1948 and that I last saw h alive on 9-19 1948.

Immediate cause of death Coronary occlusion — Duration 1 day

Due to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Fred Rupprecht

Address 600 N Wolfe St Date signed 9-21-48

VS 190 Wh

G67011 Dr. Leutscher
12 E. Eager St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12/a

Registered No. G67011

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2517 Hamilton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2517 Hamilton Avenue
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3.(a) FULL NAME WILLIAM H. WOELPER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Henrietta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1876

8. AGE: Years 72 | Months 2 | Days 9 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Benjamin Woelper
13. Birthplace Germany

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace Germany

16 (a) Informant Mrs. Henrietta Woelper
(b) Address 2517 Hamilton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Filed SEP 22 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21st 1948 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1948 to Sept 22 1948.
and that I last saw him alive on Dec 29 1947.

Immediate cause of death: Sudden death - Acute coronary occlusion — Duration: sudden

Due to: Hypertension - myocardial insufficiency Chronic nephritis 5 yrs+

Due to: Mitral insufficiency Pulmonary oedema

Other Conditions: Obesity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature John A Leutscher M.D.
Address 12 E Eager St Date signed Sept 23/48

VS 150

667012 JL - 122615

BALTIMORE CITY HEALTH DEPARTMENT ✓ 667012 Registered No.

CERTIFICATE OF DEATH 460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 837 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Willis Fulton
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Cora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): March 29. 1894
8. AGE: Years 54 Months 5 Days 19 If less than one day hr. min.

9. Birthplace: S. C. (Town, county, and state)
10. Usual Occupation: Contractor.
11. Industry or business

MOTHER / FATHER
12. Name: Harry Fulton
13. Birthplace: S. C.
14. Maiden Name: Melvina ?
15. Birthplace: S. C.

16 (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22 48 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary Cem
Location: A. A. County
18 (a) Funeral director: J. Mc Scott A. Ellen & Sons
(b) Address: 1129 N. Carrollton St
19 SEP 22 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1948 at 8.15 AM PM

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 1. 1948 to Sept. 17 1948, and that I last saw him alive on Sept. 17 1948.

Immediate cause of death: CARCINOMA OF PANCREAS — Duration: 3 Mos ?
METASTASIS TO LIVER, PLEURA,
Due to ABDOMINAL LYMPH NODES
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: SAME AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: I Howard P. Jeffries M. D.
Address: BALTIMORE CITY HOSP Date signed 9/17/48

VS 150

G67013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 131a

Registered No. G67013

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument & Rutland

(c) Hospital or institution: SINAI HOSPITAL 126

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month 5 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4319 Berger Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Madeline Madalene HEIM Heim

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife John Earl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1907

8. AGE: Years	Months	Days	If less than one day
41	7	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER — 12. Name George H. Krauk

13. Birthplace Baltimore

MOTHER — 14. Maiden Name Minnie Oltman

15. Birthplace Baltimore

16 (a) Informant John Earl Heim

(b) Address 4319 Berger Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)

(c) Cemetery or crematory Moreland Memorial

Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 Broadway.

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Sept. 1948 at 10 45 M

21. I certify that death occurred on the date above stated, that I attended deceased from 15 Sept 1948 to 20 Sept 1948, and that I last saw her alive on 20 Sept 1948.

Immediate cause of death Uremia — Duration

Due to nephrolithiasis — pyelitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: nephrolithiasis

of autopsy: renal atrophy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Louis Shaw, M.D.

Address Sinai Hospital Date signed 20 Sept

VS 150

G67014 ✓ G67014

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst., (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Eastern Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Helen Elizabeth Bauer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/17/27

8. AGE: Years 21 | Months 6 | Days 20 | If less than one day hr. min. 2

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Louis J. Bauer
13. Birthplace Balto.

MOTHER 14. Maiden Name Anita C. Madson
15. Birthplace Virginia

16 (a) Informant Louis J. Bauer
(b) Address 1815 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Glenman Hill Rd.

18 (a) Funeral director Tully & Zeiler
(b) Address 403 S. Wolfe St.

SEP 22 1948 (Date rec'd by registrar)

Huntington Williams Mill

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19/1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1946 to 9-19-1948 and that I last saw her alive on 9-18-1948.

Immediate cause of death	Duration
(a) Coronary Thrombosis	2 weeks
Due to (b) Streptococcus Infection	
Due to (c)	
Other Conditions Valvular heart Rheumatic Myocarditis	2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, place)
(e) Means of injury

23. Signature S. DeMarco M.D.
Address Medical Arts Bldg. Date signed 9-22-48

VS 150

107

667015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

667015 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Pardee
(c) Hospital or institution: St. Joseph 20th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3326 Caton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Edward Anthony Mullen

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Della Mullen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-18-97

8. AGE: Years	Months	Days	If less than one day: hr.	min.
51 50	1	3		

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Employee Balto Transit
11. Industry or business

FATHER
12. Name Peter B. Mullen
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Allen
15. Birthplace Baltimore Md.

16 (a) Informant Della Mullen (wife)
(b) Address 3326 Caton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 23 48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4360 Old Frederick Road

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 N. Collins St.

SEP 22 1948
19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1948 at 12 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1948 to 9-21 1948. and that I last saw him alive on 9-21 1948.

Immediate cause of death Myocardial Failure — Duration

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ASHD-Heart Generalized

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature. John M. Ralbrger M. D.
Address St Joseph Date signed 9-21-48

X

G67016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95

Registered No. G67016

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital [redacted] St. Joseph's

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1933 Gough Street (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Frank Mitchell Wysocki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 27, 1914

8. AGE	Years	Months	Days	If less than one day
	33	10	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Frank J. Wysocki

13. Birthplace Grabowie, Poland

MOTHER

14. Maiden Name Maryanna Andrychowska

15 Birthplace Bialowierzo, Poland

16 (a) Informant Mrs. Maryanna Wysocki

(b) Address 1933 Gough Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location German Hill Road

18 (a) Funeral director M. F. Sadowski & Sons

(b) Address 1808 Eastern Avenue

19 (a) (b) Huntington Williams M.D. Registrar

Date received by registrar SEP 22 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1948 at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12, 1948 to Sept. 20, 1948, and that I last saw him alive on Sept. 20, 1948

Immediate cause of death Pulmonary Edema — Duration

Due to Rheumatic Heart Disease - Chronic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John M Rebhuhn M. D.

Address St. Joseph Date signed 9-20-48

AI-121825
G67017

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G67017
Registered No. 128

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or da[illegible]) 1mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Watson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edward Bradshaw

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 17- 1901

8. AGE: Years 46 | Months 10 | Days 29 | If less than one day hr. [illegible] min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name William Bradshaw
13. Birthplace N.C.

MOTHER
14. Maiden Name Betty Faircloth
15. Birthplace N C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem. Brooklyn Md
Location Chas. O. Wilson
18 (a) Funeral director
(b) Address 1800 Bentley ave

19 (a) [illegible] Huntington Blvd Registrar
SEP 22 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16- 1948 at 3.40P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4- 1948 to 9-16- 1948 and that I last saw him alive on 9-16- 1948.

Immediate cause of death For advanced Pulmonary Tuberculosis — Duration 2months

Due to

Due to

Other Conditions Serology of blood Positive (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M D
Address Balt. City Hosp. Date signed 9-20-48

X

G67018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G67018
Registered No.

BC 5680

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 650 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Switzer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/27/46

8. AGE: Years 1 | Months 22 | Days 8 | If less than one day — hr. — min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Child
11. Industry or business —

FATHER
12. Name Carl H Switzer
13. Birthplace Virginia

MOTHER
14. Maiden Name Mallie Bryant
15. Birthplace Virginia

16 (a) Informant Mrs. Mallie J. Switzer
(b) Address 650 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23 1948 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Balto. Md. Frederick Rd.

18 (a) Funeral director Fred. G. Cole
(b) Address 1200 W. Lombard St.

19 (a) (b) Rec'd by registrar SEP 22 1948 Remington Williamsport Md.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1948 at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1948 to 9-20 1948 and that I last saw him alive on 9-20 1948.

Immediate cause of death	Convulsions	Duration
Due to	Encephalitis	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Freeman M. D.
Address Univ. Hosp. Date signed 9-20

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667019

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667019
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3012 West North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 West North Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME George Sisselberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Stella Sisselberger
Wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
63	9	26		

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Bank Employee
11. Industry or business

FATHER
12. Name John Henry Sisselberger
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Mary Quaid
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs. Frank Mc. Keever
Address 3012 West North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Md.

18 (a) Funeral director Mamie Cook Syfer
(b) Address 1609 W. North Ave.

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21, 1948. 10-45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1948 to Sept 21 1948; and that I last saw h[illegible] alive on Sept 21 1948.

Immediate cause of death: Duration
Sec. of Long standing
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 3033 W North Ave Date signed 9-22-48 M.D.

VS 150

G67020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67020

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Halethorpe (If outside city or town limits, write RURAL and give town)
(d) Street No. 5631 Argonne Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR GARDNER SMALLWOOD, JR.

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Daisy E. Smallwood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 10, 1905

8. AGE: Years 43 | Months 7 | Days 9 | If less than one day: hr. min.

9. Birthplace: Jessup, Md. (Town, county, and state)

10. Usual Occupation: Printer

11. Industry or business

FATHER
12. Name: Arthur G. Smallwood
13. Birthplace: Howard Co., Md.

MOTHER
14. Maiden Name: Alberta W. Hopper
15. Birthplace: Howard Co., Md.

16 (a) Informant: Mr. Lewis M. Smallwood
(b) Address: 5000 Rittenhouse St., Riverdale Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48 (month) (day) (year)
(c) Cemetery or crematory: Savage Cem.
Location: Savage, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) 1948 (b) (Registrar) Registrar

SFD
VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19 1948 at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Inqs. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Thrombosis

Due to

Other Conditions: Chronic Glomerulonephritis — Uremic Extinction
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Medical Examiner M.D.
Date signed 22 Sept 48

G67021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 129

G67021 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline Street

(c) Hospital or institution: St. Joseph's Hospital 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)

(d) Street No. 4640 Marbel Hall Road (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William Edgar Vivell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married~~, ~~widowed~~, or ~~divorced~~
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/23/33

8. AGE:

Years	Months	Days	If less than one day
14	11	28	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER 12. Name Herbert G. Vivell

13. Birthplace Mich

MOTHER 14. Maiden Name Dorothy Jane

15 Birthplace Newark Del

16 (a) Informant Herbert G. Vivell

(b) Address 4640 Marbel Hall Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24 1948 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Road

18 (a) Funeral director John C. Moran

(b) Address 3600 E Baltimore St Huntington Woodlawn, Md.

19 (a) Received SEP 27 1948 (Registrar) Registrar

VS 50

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21/ 1948 at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16/ 1948 to 9/21/ 1948 and that I last saw him alive on 9/21/ 1948

Immediate cause of death	Duration
Cerebral Thrombosis	
Jaundice	
Due to Acute Generalized Peritonitis	- 4 days
and Paralytical Obstruction	
Due to Ruptured Appendix with	6 days
Appendiceal Abscess.	
Other Conditions - Bronchopneumonia	- 2 days.

(Include pregnancy within 3 months of death)

Date of operation - 9/16/48

Major findings of operation: - Ruptured Appendix & abscess + Peritonitis

of autopsy: Generalized Peritonitis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Eugene L. Riley

Address St Joseph's Hospital Date signed 9/21/48

G670222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G670222

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1337 Gay Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1337 Gay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CLARENCE LANGLEY (LANGELEY)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1880

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month)
(c) Cemetery or crematory
Location University Medical School SEP 16 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948, at M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Autopsy pending Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Rupp M.D.
Medical Examiner
Date signed 28 Aug 48

VS 151

G67023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G67023

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Belvedere & Greenspring

(c) Hospital or institution: Levindale

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1723 Thomas Ave. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME CARL METH (CARL METH.)

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-18-9429

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Erna Meth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1890.

8. AGE: Years	Months	Days	If less than one day
57	9	4	hr. min.

9. Birthplace Germany. (Town, county, and state)

10. Usual Occupation Stock ClerK; National

11. Industry or business Casket Co.

FATHER: 12. Name Moritz Meth,

13. Birthplace Austria.

MOTHER: 14. Maiden Name Sophie Loewensohn,

15. Birthplace Austria.

16 (a) Informant Mrs. Erna Meth,

(b) Address 1723 Thomas Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/48. (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew

Location Baltimore, Md.

18 (a) Funeral director Chas. Sonnheim & Son

(b) Address 1902 Eutaw Place, Baltimore, Md.

19 (a) Sep 22 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1948 at 7:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1948 to 9-22 1948 and that I last saw h[illegible] alive on 9-22 1948

Immediate cause of death

Melanosarcoma Liver — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry Nagel M. D.

Address Levindale Home Date signed 9-22-48

VS 150

667024

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 123

667024 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 Colvert St
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Mt. Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Greenberry Road (If rural give location)
(e) Citizen of foreign country? Yes or No. If yes, name country

3 (a) FULL NAME Harry Meyers Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Married

6 (b) Name of husband or wife Mrs Harry Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 10 1885

8. AGE: Years	Months	Days	If less than one day: hr.	min
63	10	12		

9. Birthplace W. Virginia (Town, county, and state)
10. Usual Occupation Clothing Manufacturing
11. Industry or business

FATHER
12. Name J.H. Myers
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Rosenauer
15. Birthplace Maryland

16 (a) Informant Mrs. Irene H. Myers
(b) Address 2015 Greenberry Rd

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Harris Sonnenborn
(b) Address 902 Eutaw Place

19 SEP 22 1948 Date rec'd by registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1948, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1948, to Sept 22 1948, and that I last saw him alive on Sept 22 1948 at 6 AM

Immediate cause of death Acute Gangrene of bowel (large) — Duration 6 hours

Due to Mesenteric Thrombosis - 8 hours (Interval between onset and death)

Due to Endocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept 22 1948

Major findings of operation: Acute Gangrene of Bowel + Mesenteric thrombosis

Autopsy? — Endocarditis

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

Signature M. F. Coyle M.D.
Address Union Memorial Hosp. Date signed 9-22-48

G67025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G67025
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) 9540

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Bowen Court
(If rural give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Mary Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife John Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 12, 1887

8. AGE: Years	Months	Days	If less than one day
61	6	7	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Sam Rosson
13. Birthplace West Indies

MOTHER
14. Maiden Name Margaret Carter Robinson
15. Birthplace Baltimore

16 (a) Informant Margaret Carter
(b) Address 412 Bowen Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Balto., Md.

18 (a) Funeral director Charles R. Lawn
(b) Address 802 Mad. Ave.

19 (a) Filed Sept 22 1948 (b) (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1948 to Sep. 19 1948 and that I last saw her alive on Sept. 19 1948.

Immediate cause of death	Duration
Cardio-respiratory collapse	
Due to Hypoglycemia	
Due to Diabetes mellitus	
Other Conditions Bilat amputations, Leg ulcers, chronic, general	

Date of operation 8 Aug 26, 1948

Major findings of operation: Diabetic gangrene left foot

of autopsy? Same or other conditions

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature T. Swinski, M.D.
Address Mercy Hosp. Date signed 9/19/48

X

667026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

667026
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Payson + Fayette Sts.
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write CLEAR and give town)
(d) Street No. 5 N. Catherine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Kleophas Haiden

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6th 1887

8. AGE: Years	Months	Days	If less than one day
61	8	16	hr. min

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Ship Yard

FATHER
12. Name Kleophas Haiden
13. Birthplace Germany

MOTHER
14. Maiden Name Josephine Faschinger
15. Birthplace Germany

16 (a) Informant Mrs. Rose M. Haiden
(b) Address 5 N. Catherine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Cowan + Son
(b) Address 901-03 Hollins St.

19 (a) [illegible] 48 (b) Lexington Building, Md.
(Date rec'd by registrar) Address Bon Secours Hosp. Date signed 9/22/48

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1948, at 2 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 1948, to Sept. 22 1948, and that I last saw h alive on Sept. 22 1948.

Immediate cause of death ~~Circulation,~~ collapse Pulmonary embolus — Duration

Due to massive + generalized thrombosis

Due to arteriosclerotic C V D

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary infarct

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature D S Mohler

M. D.

IF DEATH OCCURRED IN A HOSPITAL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

✓ G67027 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Siani Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2328 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Henneman

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 214-03-0012

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 12, 1901

8. AGE: Years	Months	Days	If less than one day
47	1	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Bill Poster

11. Industry or business Morton Outdoor Sign Co.

FATHER
12. Name Charles E. Henneman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Minnie A. Rider
15. Birthplace Baltimore, Md.

16 (a) Informant Bertha Moore
(b) Address 457 E 23rd St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) SEP 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1948, at 11:15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/17 1948, to 9/21, 1948, and that I last saw him alive on 9/21 1948.

Immediate cause of death: UREMIA — Duration:

Due to ACUTE HEMORRHAGIC NEPHRITIS

Due to PNEUMONIA,

Other Conditions CHRONIC GLOMERULO-NEPHRITIS, CARDIAC FAILURE.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C.M. Silvestro. M. D.
Address Siani Hospital Date signed 9/21/48

VS 150

C.M. Silvestro 1092

667028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No. 667028

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 CHANCERY RD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ADELE D YOST

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife GEORGE YOST
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 1-29-85

8. AGE: Years	Months	Days	If less than one day
63	7	22	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name CHAS. DANKMEYER
13. Birthplace Md.

MOTHER
14. Maiden Name LENA OHLE
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 E. Fayette St.

19 (a) SEP 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 21 1948 at 11 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1948 to 9-21 1948. and that I last saw HER alive on 9-21 1948.

Immediate cause of death: Subarachnoid hemorrhage, multiple — Duration: 3 wks.

Due to: Probable congenital aneurysm of Circle of Willis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) (While at work?)
(e) Means of injury

23. Signature John B. Bull M.D.
Address
Date signed Sept 21, '48

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

667029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

667029 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2435 Eutaw Place
(c) Hospital or institution: 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Ben Paul Sandy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5, 1903

8. AGE: Years	Months	Days	If less than one day
45	1	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Dentist

FATHER
12. Name Jacob Sandy
13. Birthplace Russia

MOTHER
14. Maiden Name Tobe Shockett
15. Birthplace Russia

16 (a) Informant Harry Freiman
(b) Address 2435 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mount Carmel Cem.
Location German Hill Road

18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1114-26 N. North Avenue

19 SEP 23 1948 (Date received by registrar) Huntington Williams, M.D.

VS 192

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 48 at 2 P M

21. I certify that death occurred on the date above stated, that I attended deceased from June 10 1945 to Sept 14 1948 and that I last saw him alive on Sept 14 1948.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Samuel J. Hankin
Address 2331 Eutaw Pl. Date signed 9/22/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 67050

67050

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3015 Frederick, Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Frederick, Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GERRIT J. HOCKSTRA.

3 (b) If veteran, name war none.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White.	Married.

6 (b) Name of husband or wife Maria G. Hockstra.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5-1885

8. AGE: Years	Months	Days	If less than one day
62	11	17	hr. min.

9. Birthplace Enk - Holland. (Town, county, and state)
10. Usual Occupation Baker.
11. Industry or business

FATHER
12. Name Tjeerd Hockstra.
13. Birthplace Holland.

MOTHER
14. Maiden Name Gast.
15. Birthplace Holland.

16 (a) Informant Mrs. Fred G. Hockstra.
(b) Address 809 Herndon Court.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Sept. 25/48. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Sefwood.
(b) Address 3512 - Frederick, Ave.

19 (a) SEP 23 1948 (Date rec'd by Registrar) (b) Interment, Removal, Cremation

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1948 at 2.35 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1948 to Sept 22 1948 and that I last saw h[illegible] alive on 22 Sept 1948

Immediate cause of death	Duration
Coronary Thrombosis	7 hrs.
Due to Arteriosclerosis	?
Due to	
Other Conditions Angina pectoris	4 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Liliensfeld M. D.
Address 714 S. Paca St. Date signed 23 Sept 48

VS 190

X Liliensfeld

G670.31

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G670.31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St.
(c) Hospital or institution: Maryland Genl Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1932 N Washington St #B (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Clifford

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-4167

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife Bernard 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 2, 1887

8. AGE: Years 61 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Sales Lady

11. Industry or business

FATHER 12. Name John Wheeler
13. Birthplace Md

MOTHER 14. Maiden Name Maggie Parkinson
15. Birthplace Md

16 (a) Informant Mrs Rachel Mowry
(b) Address 1932 N Wash St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Rd

18 (a) Funeral director Edw Tomlson
(b) Address 2359 Greenmount Blvd

19 (a) SEP 23 1948 (Date rec'd by registrar) (b) Wellington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Sept 1948, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1948 to 9/22 1948 and that I last saw h alive on 9/22 1948.

Immediate cause of death: Extensive metastatic Carcinoma of Head & Pancreas

Due to

Due to

Other Conditions Ascites

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: 9/22/48

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. A. Cannano M. D.
Address Md. Gen'l Hosp Date signed 9/22/48

VS 150

66720.32

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12a

Registered No. 66720.32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2525 N. Calvert Street
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2525 N. Calvert Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Sophia Hipsley

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Harry Lee Hipsley
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept-11-1865

8. AGE: Years 83 | Months 0 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: None

FATHER
12. Name: John Ruhl
13. Birthplace: Germany

MOTHER
14. Maiden Name: Catherine Zimmerman
15. Birthplace: Germany

16 (a) Informant: Mrs. W. H. Naudain (daughter)
(b) Address: 2525 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept-23-1948. (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 102 E. North Avenue, City #1.

19 SEP 23 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1948, at 5:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1948 to Sept. 21 1948 and that I last saw h[illegible] alive on Sept. 21 1948.

Immediate cause of death: Bronchopneumonia — Duration 6 Days.
Due to Arteriosclerosis — Not Known
Due to Chronic Myocarditis — Not Known
Other Conditions Nephritis

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature Fulton R. Linton M. D.
Address 2824 St. Paul St Date signed 9/23/48

VS 150

93D

G670333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G670333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Dallas (If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 Park Row (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myron Sigel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-17-33

8. AGE: Years 15 | Months 3 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER — 12. Name Hyman Sigel
13. Birthplace Poland

MOTHER — 14. Maiden Name Adge Berman
15. Birthplace Texas

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-23-48 (month) (day) (year)
(c) Cemetery or crematory Dallas Texas
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 SEP 23 1948 (Date rec'd by registrar) (b) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1948, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1948 to Sept 22 1948 and that I last saw h alive on Sept 22 1948.

Immediate cause of death: Cerebral Anaemia — Duration

Due to Congenital Heart Disease

Due to Streptococcus Sepsis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Streptococcus Sepsis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Dale Cooley M.D.
Address Johns Hopkins Hosp Date signed Sept 22, 1948

VS 159

G67034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. G67034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Asylum Home
(c) Hospital or institution 3520 Helton Road
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 Ruxton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Max Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Rose Schneider
(b) Address 1822 Ruxton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) SEP 23 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1944 at 12:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to Sept 23 1944, and that I last saw h[illegible] alive on Sept. 22 1944.

Immediate cause of death: Cerebral Thrombosis — Duration: 7 days
Due to: Generalized Arteriosclerosis, Hypertension Cerebro-Vascular — ?
Due to: Diseases — ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F Lerner M. D.
Address 2401 W. North Ave Date signed 9/23/44

6670.55

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

✓ 6670.55 Registered No.

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2 USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(b) City or town Baltimore (If outside city or town limits, write in RURAL and give county)
(d) Street No. 634 Sarah Anne Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THOMAS POWELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Eleanora Perkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 23, 1908

8. AGE: Years 40 | Months 1 | Days 27 | If less than one day: hr. min

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Longshoreman

11. Industry or business:

FATHER
12. Name: Thomas Powell, Sr.
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Cassie
15. Birthplace: Maryland

16 (a) Informant: Eleanora Powell
(b) Address: 633 Sarah Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 24 1948 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location

18 (a) Funeral director: Katie R. Williams
(b) Address: 322 N. Schroeder St.

19 SEP 23 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19 1948 at 7:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide X, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hemorrhage

Due to: Edward Powell

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-19-48 at 2:15 P.M.
(b) Where did injury occur? 633 Sarah Anne Street
(c) Did injury occur at home, on farm, in industrial place, in public place? in home While at work? No
(d) Means of injury: Sharp Instrument

23. Signature: Earl L. Kay M.D.
Medical examiner

Date signed 9-20-48

V6 151

67036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1348

Registered No. 6370.56

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 HAMPSON ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH WALLACE
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race COLORED. | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife SARAH ISABELLE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1872

8. AGE: Years 76 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace REISTERSTOWN, MD. (Town, county, and state)

10. Usual Occupation UNEMPLOYED.

11. Industry or business

FATHER 12. Name John Wallace. 2nd.
13. Birthplace

MOTHER 14. Maiden Name Elizah Madden
15. Birthplace Md.

16 (a) Informant Norman Wallace.
(b) Address 5204 Denmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Location Reisterstown, Md.

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N. Schroeder St. Burlington Indiana, Md

SEP 22 1948 (Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1948 at 7.50 P M

21. I certify that death occurred on the date above stated, that I attended deceased from SEPT 5 1948 to SEPT 20 1948. and that I last saw him alive on SEPT 20 1948

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	
Due to TOXEMIA DUE TO URINARY EXTRAVASATION	
Due to URETHRAL STRICTURE	
Other Conditions VESICAL CALCULI AND DIVERTICULAE	

(Include pregnancy within 3 months of death)

Date of operation SEPT 5, 1948

Major findings of operation: URINARY EXTRAVASATION

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
(23) Signature J. Joseph Krejci
Address 1400 N. Caroline St. Date signed 9-20-48

IMPORTANT: WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians—please write the causes of death clearly and legibly.

66770.37

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66770.37

12.1a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIVERSITY Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town White Hall Road
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIOLETTA A. BUCHANAN
3 (b) If veteran, name war
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	COL	MARRIED

6 (b) Name of husband or wife RICHARD
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) MARCH 31 1905

8. AGE: Years 43 | Months 5 | Days 21 | If less than one day: hr. 2 min

9. Birthplace HARTFORD Co MD (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Christy
13. Birthplace MD

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Richard Buchanan
(b) Address White Hall, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25 1948 (month) (day) (year)
(c) Cemetery or crematory St Ignatius
Location Bel Air Md

18 (a) Funeral director Howard S Hamblin
(b) Address White Hall Md

SEP 23 1948 (Date filed) (b) — (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22-48 19 , at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 1948 to 9-22 1948 and that I last saw her alive on 9-22 1948.

Immediate cause of death	Duration
Resp. Fail. & cardiac failure	
Due to Hypertensive disease C-V	
Due to Renal insufficiency probable chronic nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underlying cause to which death should be charged (Specify)

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John White M D
Address University Hosp. Date signed 9-22-48

VS 150

66703.38

LH - 123018

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 66703.38
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name of township)
(d) Street No. 1557 Argyle Avenue
(If rural, give road and number)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME
Rebecca Berry
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Wid.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12/22/98
8. AGE: Years 50 Months Days If less than one day: hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name George Davis
13. Birthplace Va.
14. Maiden Name Julia Davis ?
15. Birthplace Va.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof Sept. 24, 194[illegible] (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Ender, Md.
18 (a) Funeral director Charles H. Alexander
(b) Address 1200 McCulloh St. Baltimore, Md.
19 (a) [illegible] (b) [illegible] Registrar

Sep 28 1948
Date rec'd by Registrar

vs ss

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 21, 48 at 7:00 AM.
21. I certify that I attended the deceased from Sept. 1, 48 to Sept. 21, 48
and that I last saw [illegible] alive on [illegible]
Immediate cause of death

Duration

Due to

Due to

Other Conditions
Resuscitation

Date of operation
Major findings of operation:

PHYSICIAN

of autopsy:
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur?
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
23. Signature M. D.
Address [illegible] Date signed [illegible]

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The [illegible] CAPITALS INK.

66703 ✓ 66703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 112a

Every item of information should be carefully supplied. The WHITE FRIEND, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison & Linden Ave.

(c) Hospital or institution:

Maryland General Hospital

(d) Length of stay in hospital or inst. yrs., mos., or days 70 days

(e) Length of stay in Baltimore yrs., mos., or days life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Woodlawn

(If outside city or town limits, write RURAL and give town)

(d) Street No. Hutton Ave. & Oak Drive

(If rural, give location)

(e) Citizen of foreign country? Yes or No

If yes, name country

3 (a) **FULL NAME** John L. Mc Laren

3 (b) If veteran, name war none

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edna G. McLaren

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. June 8, 1910

8. **AGE:** Years 38 Months 3 Days 13 If less than one day hr. min

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Administrative Office

11. Industry or business Federal Service

FATHER

12. Name Robert McLaren

13. Birthplace Ureka, California

MOTHER

14. Maiden Name Mary J. Irwin

15. Birthplace Balto., Md.

16 (a) Informant Mrs. Edna G. McLaren

(b) Address Hutton Ave. & Oak Drive, Woodlawn

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof 9/25/48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

SEP 23 1948 (Date rec'd by registrar)

Huntington Williams, M.D.

VS 50

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1948 2:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 2 1921 to Sept 21 1948, and that I last saw h[illegible] alive on Sept 21 1948

Immediate cause of death (a) Shock

Duration

Due to

Due to

Other Conditions

(Describe relationship, if any, between causes of death)

Date of operation 2-24-43

Major findings of operation:

Gastric Ulcer

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 9-21-48

67040

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

67040 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5007 Ross Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2145 Chelsea Terr.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME ELIZA R. WALTER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George W. Walter
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 31, 1870

8. AGE: Years: 77 | Months: 8 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: William W. Elliott
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Emma Isaacs
15. Birthplace: Ellicott City, Md.

16 (a) Informant: Mr. George W. Walter
(b) Address: 2145 Chelsea Terr.

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof: 9/24/48 (month) (day) (year)
(c) Cemetery or crematory: Trinity Cem.
Location: Long Green, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 25 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 19 48 at 8:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/ /48 to 9/21/ 19 48, and that I last saw h[illegible] alive on 9/21/ 19 48

Immediate cause of death: Coma (Myocardial Infarction) — Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 2145 Chelsea Terr. Date signed 9/24/48

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G67041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 82a

G67041

Registered No.

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 722 Hollen Rd.
(c) Hospital or institution:

27

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 722 Hollen Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATIE M. PEARCE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Parker M. Pearce
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1885

8. AGE: Years	Months	Days	If less than one day
63	7	20	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George C. Kramer
13. Birthplace Holland

MOTHER
14. Maiden Name Minnie Phiester
15. Birthplace Balto., Md.

16 (a) Informant Mr. Parker M. Pearce
(b) Address 722 Hollen Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory Fork Christian Cem.
Location Fork, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 23 1948 (Date rec'd by registrar) Barrington Hillegeist Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1948 at 4:00 a M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1946 to Sept 22 48.
and that I last saw h alive on Sept 21 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	10 days
Due to Arteriosclerosis cerebral	5 yrs.
Due to Hypertension	10 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature H. F. Shaffer Thos M.D.
Address 620 Light St Date signed Sept 22 48

VS 150

G67042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G67042 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 N. High Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: EDGAR LOGAN BUNN

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-01-7058

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife: Anna Bunn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1884

8. AGE: Years	Months	Days	If less than one day
64	2	6	hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Clerk (retired)
11. Industry or business: Balto. News

FATHER
12. Name: John Snyder Bunn
13. Birthplace: New Jersey

MOTHER
14. Maiden Name: Eliza E. Pitt
15. Birthplace: New Jersey

16 (a) Informant: Mrs. Kathryn E. Bunn
(b) Address: 2638 E. Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 23 1948 (Date rec'd by registrar) (b) Livingston Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1948 at 10 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic cardiovascular disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Carl L. Rogers M.D.
Medical Examiner.
Date signed 9-23-48

VS 151

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

667043 Registered No.

PRINT CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or Institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 N. Charles (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Dorn, Florence Louise

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-24-9756

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 16, 1917

8. AGE: Years	Months	Days	If less than one day: hr.	min.
31	1	17	7	

9. Birthplace Casper, Wyoming (Town, county, and state)

10. Usual Occupation Administration Ass't. (U.S. Gov't)

11. Industry or business Fort Meade, Md.

FATHER 12. Name Martin Dorn
13. Birthplace Buffalo, N. Y.

MOTHER 14. Maiden Name Regina Aichele
15 Birthplace Baltimore, Md.

16 (a) Informant Miss Eva Dorn
(b) Address 2701 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory St. Paul's Cem.
Location Druid Hill Pk., Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 23 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1948, at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 30 1948 to Sept. 23 1948, and that I last saw her alive on Sept. 23, 1948.

	Duration
Immediate cause of death Toxemia with cardio-respiratory failure	36 hours
Due to Left lower lobe pneumonia	36 hours
Due to	
Other Conditions Peritonitis	1 month

(Include pregnancy within 3 months of death)

Date of operation 8/16/48 9/18/48

Major findings of operation: Intra-abdominal adhesions, Pelvic abscess

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature J. Joseph Kagin M. D.
Address 1400 N. Caroline St. Date signed 9/23/48

VS 150

G67044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G67044

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 925 E.30th.,Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 925 E.30th.,Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary T.Doud

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: Thomas F.Doud
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Feb.2nd.,1885

8. AGE: Years	Months	Days	If less than one day
63	7	20	########## min.

9. Birthplace Baltimore,Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Timothy J.Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Ann Dowd
15. Birthplace Ireland

16 (a) Informant Philip & Terence Doud (Sons)
(b) Address 925 E.30th.,Street

17 (a) Burial (b) Date thereof 9/25/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Avenue,BaltoCo.Md.

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue

19 (a) [illegible] (b) [illegible]
(Certified by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 19 48 to 9/22 19 48.
and that I last saw her alive on 9/20 19 48.

Immediate cause of death	Duration
Coronary Embolism	Immediate
Due to -------	
Due to ------	
Other Conditions Hyperacidity	about 1 month

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. W. Morgan M.D.
Address 401 E.25th. St. Date signed 9/23/48.

V S 150

667045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

667045
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~3014 LINWOOD AVE~~
(c) Hospital or institution: MARYLAND GEN. HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE #14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 LINWOOD AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. CATHERINE E. HEILL

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: HENRY PAUL HEILL

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): NOV. 30, 1903

8. AGE: Years 44 | Months 9 | Days 24 23 | If less than one day: hr. ____ min.

9. Birthplace: BALTIMORE
(Town, county, and state)

10. Usual Occupation: HOUSEWIFE

11. Industry or business

FATHER
12. Name: JOSEPH KUBENIK
13. Birthplace: EUROPE

MOTHER
14. Maiden Name: MARY SUCHANEK
15. Birthplace: EUROPE

16 (a) Informant: HUSBAND
(b) Address: SAME

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 | 27 | 48 (month) (day) (year)
(c) Cemetery or crematory: Moreland Park
Location: Baltimore

18 (a) Funeral director: D. Luck Hartford Co.
(b) Address: 5305 Washington Blvd. Md

19 (a) (Date rec'd by registrar) 9-28-48 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 23 1948 at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 20 1948 to SEPT 23 1948 and that I last saw HER alive on SEPT 23 1948

Immediate cause of death: PULMONARY EDEMA — Duration: 3 HOURS

Due to: UREMIA

Due to: CHRONIC NEPHRITIS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: REFUSED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Donald L. England M. D.
Address: MARYLAND GEN HOSP Date signed: 23 SEPT 48

VS 150

X

IF NOT PLAINLY WRITTEN WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67046

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G67046
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE WRITING FLUID, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3036 Woodside Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Edward Wilkinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mattie Virginia

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr: Dec 25-1901

8. AGE: Years 46 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Western Md dairy

11. Industry or business

FATHER
12. Name: Thomas Wilkinson
13. Birthplace ✓

MOTHER
14. Maiden Name: Mary Virginia
15. Birthplace ✓

16 (a) Informant: Mrs. M. V. Wilkinson
(b) Address: 3036 Woodside

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-48 (month) (day) (year)
(c) Cemetery or crematory: Moreland Park
Location: Balto

18 (a) Funeral director: L. J. Luck
(b) Address: 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Sept 1948. at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1948. to 9/22 1948. and that I last saw h[illegible] alive on 9/22 1948.

Immediate cause of death: Cardiac Tamponade.

Duration:

Due to

Due to

Other Conditions: Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac Tamponade, Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Ernest C Peramo M D
Address: Md Gen'l Hosp Date signed 9/23/48

VS 150

G67047

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

✓ G67047
Registered No.

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 Alisanna St.
(c) Hospital or institution:

2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Alisanna St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Walters

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widower

6 (b) Name of husband or wife Mary Bullock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/17/93

8. AGE: Years	Months	Days	If less than one day
55	9	5	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Oyster - Fishery

FATHER
12. Name John C. Walters
13. Birthplace Balto

MOTHER
14. Maiden Name Mary Grimm
15 Birthplace Balto

16 (a) Informant Margaret Beetz
(b) Address 1815 Alisanna St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Easton Ave - Govd.

18 (a) Funeral director Tilly & Zeller Inc
(b) Address 403 N. Wolfe St

SEP 23 1948 (Date rec'd by registrar) (b) Washington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22/1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1941 to Sept 22 1948
and that I last saw h[illegible] alive on Sept. 1 1948

Immediate cause of death Coronary Thrombosis — Duration acute

Due to Coronary Atherosclerosis (Yr.)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address Date signed 9/24/48

VS 159

G67048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G67048

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Druid Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3416 Virginia Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** albert whyte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	white	widower

6 (b) Name of husband or wife Elizabeth S. Whyte

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1882

8. AGE: Years	Months	Days	If less than one day
66	0	29	hr. min.

9. Birthplace unknown, (Town, county, and state)

10. Usual Occupation

11. Industry or business Race Track

FATHER 12. Name John McClymont Whyte,

13. Birthplace Canada?

MOTHER 14. Maiden Name Elizabeth Ashcroft,

15. Birthplace Canada?

16 (a) Informant Mrs. Harry Graham,

(b) Address 4316 Virginia Ave.,

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18 (a) Funeral director C. Vernon Lemmon.

(b) Address 4611 Park Heights Ave.

19 (a) (Date received by registrar) (b) Burial Permit Issued by

SEP 28 1948 Evelyn Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1948 at 12:3A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1948 to Sept 22 1948 and that I last saw h[illegible] alive on Sept 22 1948.

Immediate cause of death Cardio-Resp-Renal failure — Duration

Due to Carcinomatosis from carcinoma of sphenoid

Due to Uremia

Other Conditions Ileal fistula-colostomy

(Include pregnancy within 3 months of death)

Date of operation 7/29/48; 8/12/48

Major findings of operation: Carcinoma of sphenoid sinus

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert H Mackey M. D.

Address [illegible] Date signed 9/24/48

EVS 150

G67049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G67049 Registered No.

Type or print in UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address So. Balt. Gen. Hosp.
(c) Hospital or institution: Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto. (b) County Md.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 E. 24th St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Doughton Patricia Robert Wingen WINEGAR

3 (b) If veteran, name war —

(c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9 | 15 | 48

8. AGE: Years | Months | Days | If less than one day hr. 15 min.

9. Birthplace So. B.G.H. - Balt., Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Robert Wingen
13. Birthplace Alabama

MOTHER
14. Maiden Name Patricia Fonahill
15. Birthplace Balt. Md.

16 (a) Informant Patricia Fonahill Wingen
(b) Address 313 E. 24th St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 22 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 23 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 | 15 | 48 (Month) (Day) (Year) at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15/48 to 9/15/48, and that I last saw h[er] alive on 9/15/48.

Immediate cause of death Atelectasis due to Prematurity — Duration 15 min.

Due to Prematurity

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 836 H Date signed 9/16/48 M.D.

667050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

182

Registered No. 667050

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pier 9, Locust Point
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Oregon (b) County
(c) City or town Portland (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 Burnside St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifford NEWKIRK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1889

8. AGE: Years 59 Months Days If less than one day hr min

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day)

(c) Cemetery or crematory

Location University Medical School SEP 14 1948 Commissioner of Health

18 (a) Funeral director

(b) Address

19 (a) SEP 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1948, at 7:55AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH:
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury August at 1948 M.
(b) Where did injury occur? Harbor, Pier 9, Locust Point
(c) Did injury occur at home, on farm, industrial place or public place? Pier 9 While at work? ?
(d) Means of injury Drowning

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8/19/48

VS 131

Every item of information should be carefully supplied. TYPEWRITER, WITH DEADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 66701

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Barre Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN TOWNSEND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1917

8. AGE: Years	Months	Days	If less than one day: hr.	min.
31				

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 14 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) SEP 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1948, at 7:40 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured skull with intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:

(a) Date of injury Found: 8-30-48 at 5:30 A M.

(b) Where did injury occur? Found: Howard & Camden Sts.

(c) Did injury occur at home, on farm, industrial place, in public place? public (While at work?) no

(d) Means of injury: Fell to ground during epileptic

23. Signature George L. Merrill M.D.
(Medical Examiner.)

Date signed 9/3/48

Medical Exam. case -

670552 D. O. A

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

670552 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city limits, write RURAL, and give town)
(d) Street No. 1511 Vermont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Brady

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jamaney B. Brady 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) January 16, 1897

8. AGE: Years 51 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Lee Gavin

13. Birthplace Va.

MOTHER 14. Maiden Name Lillie

15 Birthplace Va.

16 (a) Informant.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 23/48 (month) (day) (year)

(c) Cemetery or crematory
Location Goochland Co. Va.

18 (a) Funeral director Mrs. Robert A. Ellison Dept.
(b) Address 1129 N. Carolina St.

19 (a) SEP 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Signature of registrar)

vs 150 To be appro. by the Med. Examiner

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20-1948 to 9-20-1948 and that I last saw h[illegible] alive on 9-20-1948.

Immediate cause of death: Lobar pneumonia — Duration: days.

Due to bacterial infection — days.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lobar pneumonia, Rt.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Anthony J. Zito M.D.
Address Johns Hopkins Hosp. Date signed 9-21-48

Certification approved by [illegible]

For John R. Davis, M.D.

Physicians are especially important. Physicians: please write the causes of death clearly and legibly.

BC-48-20125

667053

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667053

159a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or Institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 N. Duncan (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Szymski, Mary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1948

8. AGE: Years	Months	Days	If less than one day: hr.	min.
		8		

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Adam James Szymski
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Hilda Mary Szymski
15. Birthplace Baltimore, Md.

16 (a) Informant Adam J. Szymski
(b) Address 404 N. Duncan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Mark Groceloss
(b) Address 900 N. Charles St

19 (a) SEP 23 1948 (Date received by registrar) Registrar Washington, D.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1948 at 4:35AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19, 1948 to Sept. 23, 1948 and that I last saw her alive on Sept. 23, 1948

Immediate cause of death	Duration
Medullary Herniation	
Due to Spina bifida, Hydrocephalus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify Yes or No)
(e) Means of injury

23. Signature John Belluzzo M. D.
Address St. Joseph Date signed 9-23-48

VS 150

Sheet size is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

G67054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G67054

Registered No.

The correct age is especially important. Physicians: please complete the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1332 W. 41st Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1332 W. 41st Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Annie C. Longenecker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife: Solomon Longenecker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): May 15, 1864

8. AGE: Years 84 | Months 4 | Days 7 | If less than one day: hr. min.

9. Birthplace: Graceham, Frederick Co., Md. (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: George D. Hoover
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Susan Shearer
15. Birthplace: Maryland

16 (a) Informant: Mrs. Mary Grace Rairigh
(b) Address: 1332 W. 41st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory: Meadow Branch
Location: Westminister, Maryland

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 3631 Falls Road

19 (a) SEP 23 1948 (Date received by Registrar) (b) Huntington Williams, M.D. (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH September 22, 1948, at 3.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1948 to 9/22 1948, and that I last saw h[illegible] alive on 9/21 1948.

	Duration
Immediate cause of death: Arteriosclerotic heart	yrs
Due to Arteriosclerosis	yrs
~~Due to~~ cerebral thrombosis	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address 2020 N. Charles Date signed 9/23/48 M. D.

667055

Sr. 5406

667055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 12 12

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible] Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Angela Sell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert Sell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1917

8. AGE: Years 31 | Months 2 | Days 14 | If less than one day: hr. min.

9. Birthplace Maryland, Carroll County
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Doyle
13. Birthplace Maryland

MOTHER
14. Maiden Name Carrie McCaffrey
15. Birthplace Maryland

16 (a) Informant Hosp. Records
(b) Address Funeral Dir.

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof Sept 25 48 (month) (day) (year)
(c) Cemetery or crematory St Johns Cemetery
Location Westminster Carroll Co.

18 (a) Funeral director J. Bankard & Son
(b) Address Westminster Md.

19 SEP 24 1948 (Date rec'd by registrar) Westminster, Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1948 at 10 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22/48 19 to 9/23 19, and that I last saw her alive on 9/23 1948.

Immediate cause of death: Cardio-respiratory Collapse — Duration

Due to: Chronic glomerular nephritis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. Siwinski

Address Mercy Hosp Date signed 9/24/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

VS 150

667056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

667056
Registered No.

Type or print in ink. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Same St (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 H Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James J. O'Toole

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-27-80

8. AGE: Years 68 | Months 2 | Days 24 | If less than one day: hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name William O'Toole
13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget Nora
15. Birthplace Ireland

16 (a) Informant Same
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 25 1948 (month) (day) (year)
(c) Cemetery or crematory RIVERVIEW CEMETERY
Location WILMINGTON DELAWARE

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 WINDSOR AVE.

19 SEP 24 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23-1948, at 6 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8-1948, to 9-23 1948, and that I last saw h/m alive on 9-22 1948.

Immediate cause of death: Carcinoma of Liver — Duration

Due to: Obstruction of Jejunum

Due to:

Other Conditions:

(Interval between onset and death) months (of death)

Date of operation 9-21-48

Major findings of operation: Same as above

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William O'Toole M. D.
Address Same Date signed 9-23

VS 150

667057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667057

B-115594

47c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 S. Newkirk St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie M. Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1887

8. AGE: Years 61 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name Frederick Wissussek
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant RECORDS. Balto City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory ST. PAUL'S FIFTH REFORMED CHURCH
Location BALTO. MD.

18 (a) Funeral director Roland L. Fuller
(b) Address 2112 DUNDALK AVE.

19 (a) SEP 24 1948 (Date received by local registrar) (b) Huntington, Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21 1948 at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1947 to 9-21 1948, and that I last saw h er alive on 9-21- 1948.

Immediate cause of death: Bronchogenic carcinoma — Duration: 1 yr.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Kerlan Jr. M. D.
Address Balto City Hosp. Date signed 9-22-48.

VS 150

G667058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G667058

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 WYETH ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 WYETH ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LYDIA BREITENBACH

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	MARRIED

6 (b) Name of husband or wife LOUIS BREITENBACH 6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) MARCH 20 1887

8. AGE: Years	Months	Days	If less than one day
61	6	3	hr. min.

9. Birthplace VIRGINIA. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business —

FATHER
12. Name NOT KNOWN
13. Birthplace NOT KNOWN

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace NOT KNOWN

16 (a) Informant LOUIS BREITENBACH.
(b) Address 609 WYETH ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT-27-48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK. CEM
Location FREDERICK. ROAD

18 (a) Funeral director BERNARD C. HARLEY
(b) Address 121 E WEST ST

19 SEP 24 1948 (Date rec'd by registrar) Huntington Wilmarth, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 23 1948, at 11:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23 1948 to 9-23 1948 and that I last saw h[illegible] alive on 9-23 1948.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Coronary Artery Disease	6 week
Due to	
Other Conditions Cholelithiasis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Upfold Jr. M.D.
Address 1222 Wash Blvd Date signed 9-24-48

VS 150

667059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667059

B - 123018

937

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied. The

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1921 Druid Hill Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Bernard Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 1 1900

8. AGE: Years	Months	Days	If less than one day
48	7		hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name James Adams

13. Birthplace Md.

MOTHER — 14. Maiden Name Bessie Holland

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director James Astarjos

(b) Address 142 W. Hoffman St.

19 SEP 24 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1948 at 5.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16 1948 to Sept. 21 1948. and that I last saw him alive on Sept. 21 1948.

	Duration
Immediate cause of death CARDIAC FAILURE	1 MO
Due to HYPERTENSIVE CARDIOVASCULAR DISEASE	?
Due to CONGESTION OF LUNGS, LIVER, & KIDNEYS	
Other Conditions UREMIA (Include pregnancy within 3 months of death)	

Date of operation N

Major findings of operation: NONE

of autopsy: AS ABOVE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas P. Gervazoni M. D.

Address BALTIMORE CITY HOSP. Date signed 9-22-48

VS 150

G67060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G67060

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 632 W. Montgomery
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 632 W Montgomery
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1856

8. AGE: Years 82 | Months — | Days — | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Benton Wickes
13. Birthplace Md

MOTHER 14. Maiden Name Francis —
15. Birthplace

16 (a) Informant Clarence Smith
(b) Address 632 Montgomery St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25 1937 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Stavros
(b) Address 1142 W. Pratt St

19 (a) SEP 24 1937 Huntington Williams Mortuary
(Date rec'd by reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1937 at 4.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 '37 to Sept 20 '37
and that I last saw h alive on Sept 20 '37

Immediate cause of death: Cardio Vascular Renal — Duration: 1

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 9-24-37

VS 150

467061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 6520

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 S Sharp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 S. Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Lee

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Robert E. Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1890.

8. AGE: Years 58. | Months | Days | If less than one day hr. min.

9. Birthplace Annandale Co Va (Town, county, and state)

10. Usual Occupation At. Home

11. Industry or business

FATHER 12. Name George Snowden
13. Birthplace a a Co.

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant Robert E. Lee
(b) Address 1021 S. Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 26-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director James Astaras
(b) Address 142 W. Hill St

19 (a) SEP 24 1948 (Date rec'd by registrar) Huntington W. Virginia, M.E.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1948, at 11 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1948, to Sept 21 1948, and that I last saw her alive on Sept 20 1948

Immediate cause of death Chronic Nephritis
Uremic Convulsions

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Swanson M. D.
Address 142 W Lee St Date signed 9/23/48

VS 150

667062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 B

Registered No. 667062

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2307 Ashland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John H. F. Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-09-0258

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Amelia E. Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14-1880

8. AGE: Years 68 | Months 5 | Days 8 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Collector

11. Industry or business retired

FATHER 12. Name Henry Miller

13. Birthplace Baltimore

MOTHER 14. Maiden Name Agnes C. Eichel

15. Birthplace Baltimore

16 (a) Informant Mrs. Amelia E. Miller

(b) Address 2307 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.

Location Baltimore

18 (a) Funeral director Philip Herwig Sons

(b) Address 2024 Orleans St.

19 SEP 24 1948 (Date received by registrar) Cuthbert Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1948 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 1947 to Sept. 22 1948, and that I last saw him alive on Sept. 22 1948.

Immediate cause of death Carcinoma of Prostate — Duration 3 yrs?

Due to

Due to

Other Conditions Myocardial Degeneration (Include pregnancy within 3 months of death)

Date of operation Sept. 16, 1946

Major findings of operation: Carcinoma of Prostate

Autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent B. Bokka M.D.

Address 845 N. Patterson Park Ave signed 9/23/48 M.D.

VS 150

16703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 16703

Lot 121061

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 N. Rutland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Schafline (Schaflein)

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex M

5. Color or race W

6 (d) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Florence Schaflein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1879

8. AGE: Years 79 | Months 8 | Days 6 | If less than one day hr. min. 69

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name (Schaflein) Peter Schaflein
13. Birthplace Germany

MOTHER
14. Maiden Name Tillie ? Herman
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4941 Eastern ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto. Md.

18 (a) Funeral director Philip Sherry Sons
(b) Address 2024 Orleans St.

19 SEP 24 1948 (Date rec'd by registrar) (b) Clayton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 21- 1948; at 1:15 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 7-7- 1948 to 9/21 1948 and that I last saw him alive on 1948

Immediate cause of death: Toxemia

Due to: Infected amputation stump

Due to: Arteriosclerosis Senile Gangrene Left Extremities

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/23/48

Major findings of operation: Gangrene right leg

of autopsy:

Duration: age; 2 mos.; Years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman Pike M.D. M. D.

Address 4941 Eastern Ave Date signed 9-24-48

VS 150

X.

G67064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G67064 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3506 Copley Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Copley Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LUCIE G. GERE.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henri Gere.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1876.

8. AGE: Years 71 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Paris, France. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

MOTHER / FATHER
12. Name Charles Gilbert,
13. Birthplace France.
MOTHER
14. Maiden Name Unknown,
15. Birthplace France.

16 (a) Informant Mrs. Sampson Pike,
(b) Address 3506 Copley Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48. (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director [illegible] Son
(b) Address 1902 Eutaw Place.

19 (a) SEP 24 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22nd. 1948 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945. to Last 1948.
and that I last saw her alive on July 30 1948.
Immediate cause of death Cerebral Thrombosis
Due to Arteriosclerosis
and hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

Duration 9/22/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold W. Thon M. D.
Address 5721 Pk. Heights Ave. Date signed

VS 150

X

PRINT NAME PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 667065

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.,
(c) City or town (If outside city or town limits, write RAL and give town)
(d) Street No. 1001 Woodyear Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPHINE BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1902

8. AGE: Years 46 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Dendron, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Eddie Hite
13. Birthplace Va.

MOTHER
14. Maiden Name Malinda Young
15. Birthplace Va.

16 (a) Informant Alice Brown
(b) Address 1416 Shipp St. Norfolk, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-48 (month)

(c) Cemetery or crematory
Location Norfolk, Va.

18 (a) Funeral director Charles R. Law
(b) Address 302 Madison Ave.

19 SEP 24 1948 (Date rec'd by registrar) Hunting ton Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22, 1948 at 10:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Which one?
(d) Means of injury

23. Signature Howard J. Maldeis M.D. Medical Examiner
Date signed 9-23-48

(Enter age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The)

667066

667066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 131a

Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 932 - Druid Hill ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 - Druid Hill (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Hawkins.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Separated

6 (b) Name of husband or wife

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr) 7-5-1884

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation unemployed.

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant Laura Lipscomb
(b) Address 932 - Druid Hill ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-48 (month) (day) (year)
(c) Cemetery or crematory Location Mt. Calvary.

18 (a) Funeral director A. Halstead
(b) Address 916 - Druid Hill ave.

19 SEP 24 1948 (b) [illegible] (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22- 1948 at 12 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-18- 1948 to 9-22- 1948.
and that I last saw him alive on 9-20- 1948

Immediate cause of death Chronic Cardiovascular renal disease d/t Hypertension — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. T. Jackson M. D.

Address 650 N. Eutaw St. Date signed 9/24/48

VS 150

6670n7

48-10799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104a

Registered No. 6670n7

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES PICKETT

3 (b) If veteran, name war ———

3 (c) Social Security Account No. ———

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ——

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 1948

8. AGE: Years | Months 4 | Days | If less than one day ... hr. ... min

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unemployed (infant)

11. Industry or business

FATHER
12. Name ? Pickett
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Garris
15. Birthplace Unknown

16 (a) Informant Mary Garris
(b) Address 1506 E. Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. J. Hulstead
(b) Address 918 Druid Hill Ave.

19 (a) 24 1948 (b) (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1948 at 10:15 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy/ Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Upper respiratory infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Royer M.D.
Medical Examiner

Date signed

VS 151

G667058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 22a

Registered No. G667058

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 N. Lexington St.
(c) Hospital or institution: Maryland Baptist Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 N. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Silas C. Carter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Ada

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1870

8. AGE: Years 77 | Months 11 | Days 22 | If less than one day: hr. min.

9. Birthplace Westmoreland (Town, county and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER: 12. Name Silas Carter
13. Birthplace Virginia

MOTHER: 14. Maiden Name Lucy Thompson
15. Birthplace Virginia

16 (a) Informant Mrs. Daniel Ringgold
(b) Address 9025 Stalley Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) SEP 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21/48 19.. at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/19/48 to 9/21/48, and that I last saw him alive on 9/21/48

Immediate cause of death: Acute Myocarditis — Duration: 2 days

Due to: Acute Arthritis — Duration: 2 weeks

Due to: Angesope

Other Conditions: Cirrhosis of Bronchitis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Barksdale M. D.
Address 516 N. Carey St. Date signed 9/24/48

PHYSICIAN

Underline the cause to which death should be charged statistically.

PRINT PLAINLY IN PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66709 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 66709

Please WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 Mott Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland ✓ County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Mott Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME William F. Bush

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Elsie Bush

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) May 19, 1894

8. AGE: Years	Months	Days	If less than one day hr.	min.
54	4	3		

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Baltimore City Court House

11. Industry or business Library

FATHER
12. Name William F. Bush
13. Birthplace Easton Shore Maryland

MOTHER
14. Maiden Name Mathis
15. Birthplace Maryland

16 (a) Informant Mrs Elsie Bush
(b) Address 1121 McDonough St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26 1948 (month) (day) (year)

(c) Cemetery or crematory Western Run
Location Baltimore County Md

18 (a) Funeral director Joseph A Lucy

(b) Address 64 West Saratoga Street

19 SEP 24 1948 (Date rec'd by registrar) (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1948 at 8:12 P.M. 50

21. I certify that death occurred on the date stated; that I attended deceased from 8-20 1948 to 9-22-1948 and that I last saw him alive on 9-22 1948.

Immediate cause of death — Pulmonary Thrombosis
Bronchial Pneumonia — Duration 60 days
Due to Bronchial Pneumonia 10 days
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Blake Caroline M. D.

Address 1603-N Date signed 9-24-48

VS 150

G67070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

✓ G67070 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4214 Kolb ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna Lutz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Edw. B. Lutz
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr) 1-9-1888

8. AGE: Years 60 | Months 9 | Days 11/12 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Hochhausen
13. Birthplace Balto.

MOTHER
14. Maiden Name Frances Stiebel
15 Birthplace Balto

16 (a) Informant Edward B. Lutz, Husband
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25 48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Dippel Bros.
(b) Address 7110 Belair Rd.

19 SEP 24 1948 (Date rec'd by Registrar) (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1948, at 7.29 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1948 to 9-22 1948, and that I last saw her alive on 9-22 1948

Immediate cause of death Acute pulmonary edema — Duration 2 hrs.

Due to Myocardial infarction

Due to Coronary thrombosis

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ann Powell Jr

Address Mercy Hosp Date signed 9-23-48

94a

G67071

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

164a

(Registered No.) 67071

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 668 W. Fairmount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME CHARLES VINCENT emw

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-10-2429

4. Sex: M | 5. Color or race: C | 6 (d) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alverta Vincent
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 9/30/1908

8. AGE: Years: 39 | Months: 11 | Days: 23 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name: Grace
15. Birthplace: Maryland

16 (a) Informant: Alverta Vincent
(b) Address: 687 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/25/48 (month) (day) (year)
(c) Cemetery or crematory: Mt Auburn
Location: Balto. Md

18 (a) Funeral director: Charles Hurpin
(b) Address: 512 Carrollton Ave

19 (a) SEP 24 1948 (Date rec'd by registrar) Wellington Williams, MD

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1948, at 7:55 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to strangulation

Due to Hanging

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 22, 48 between 3 A.M. & 6:30 A.M.
(b) Where did injury occur? 668 W. Fairmount St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury hung self with belt

23. Signature Emil R. Roy M.D.
Medical Examiner

Date signed 9/22/48

×

Dr. Hayward 667072 BALTIMORE CITY HEALTH DEPARTMENT ✓ 667072
13 E. Eager CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3501 White Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 White Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthias Leimkuhler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 27, 1864

8. AGE: Years 83 | Months 11 | Days 2827 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Secretary, Bldg. Asso.

11. Industry or business

FATHER 12. Name John M. Leimkuhler
13. Birthplace Hanover, Germany

MOTHER 14. Maiden Name Barbara Knapp
15. Birthplace Bedan, Germany

16 (a) Informant Miss Mary Leimkuhler
(b) Address 3501 White Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road "14

19 (Date received by registrar) SEP 24 1948 Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24, 1948 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30, 1947 to Sept 24 1948, and that I last saw him alive on Sept 23 1948.

Immediate cause of death: Acute stomach collapse — Duration: 4 hours
Due to Coronary thrombosis 6 — 18 hrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. F. Hayward
Address 13 E Eager St Date signed 9th 24/48

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667073 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 6700 Youngstown Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wasil PANASUK

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-5196

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna Panasuk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Know ?

8. AGE: Years	Months	Days	If less than one day: hr.	min.
64				

9. Birthplace Russian (Town, county, and state)
10. Usual Occupation Steel Work
11. Industry or business Bethlehem Steel

FATHER
12. Name ? Panasuk
13. Birthplace Russian

MOTHER
14. Maiden Name Not Know
15. Birthplace Russian

16 (a) Informant: Mrs. Anna Panasuk
(b) Address 6700 Youngstown Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27-48 (month) (day) (year)
(c) Cemetery or crematory: Holy Trinity Russian
Location Elkridge, Md.

18 (a) Funeral director John A. Grabliauckas
(b) Address 425 S. PACA St. Washington Wilmington, Md.

19 (a) SFD 9 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 19 48, at 9:20 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism

Due to

Other Conditions fracture Rt. femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-15-48 at 6:45 P M.
(b) Where did injury occur? Bethlehem-Sparrows Pt.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Tripped and fell to floor

23. Signature Emil L. Konzo M.D. (Medical Examiner)
Date signed 9-23-48

VS 151

667074

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 127a

667074 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** FRANK MILES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Annie Miles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Henry Miles
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Annie Miles
(b) Address 1317 Madison Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

SEP 24 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21, 1948 at 3A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1948 to Sept 21 1948, and that I last saw h alive on 9/20 1948.

Immediate cause of death Coronary Occlusion — Duration 1 day
Due to Cerebral Thrombosis — 2 days
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Pearson M. D.
Address 627 N. Milton Ave. Date signed Sept 24 1948

H. L. Pearson

VS 152

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

667075

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667075 Registered No. 50

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 N. Carey St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Col) Mary Frances Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1890

8. AGE: Years	Months	Days	If less than one day
58	6	18	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Phillip Cooper
13. Birthplace Md.

MOTHER 14. Maiden Name Rosie Spencer
15. Birthplace Md.

16 (a) Informant Mrs. Susie Jackson
(b) Address 709 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) 1948 Sept 24 (Date rec'd by registrar) Wellington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Sept. 1948 at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Multiple Metastasis from Carcinoma of Breast

Due to

Other Conditions Chronic Myelogenous Leukemia.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammond - M.D. Medical Examiner
Date signed 23 Sept. 48

24

VS 151

Physicians: please write the causes of death clearly and legibly. The

BC-C09816 667076

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 667076 Registered No. 520

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood Sts.
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life..

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2641 Dulaney Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Ronald Wm Clevenger" RONALD WAYNE CLEVINGER"

3 (b) If veteran, name war ********** | 3 (c) Social Security Account No. **********

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife SINGLE
6 (c) If alive, give age S. years

7. Birth date of deceased (mo., day, yr.) Sept. 28 1944

8. AGE: Years	Months	Days	If less than one day
3	11	25 24	***hr.*******min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation None.... Child
11. Industry or business " "

FATHER
12. Name JACOB F. CLEVINGER
13. Birthplace PA.

MOTHER
14. Maiden Name GRACE M. BAILEY
15. Birthplace MARYLAND

16 (a) Informant JACOB F. CLEVINGER(fat.)
(b) Address 2641 Dulaney Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25/48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE PARK
Location WOODLAWN, MARYLAND

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 EUTAW PLACE...17
Huntington Williams, M.D.

19 (a) Date received by registrar SEP 24 1948
(b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1948 at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1948 to 9-22 1948, and that I last saw him alive on 9-22 1948.

Immediate cause of death metastatic malignancy

Due to Wilm's tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Bruns M.D.
Address Univ Hosp Date signed 9-22-48

H. J. Bruns

VS 150

Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The ages as especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Lab - 122967 G67077 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Bethelhem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Batching
3 (b) If veteran, name war
3 (c) Social Security Account No. 312-09-5253

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Caroline
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 7. 1900
8. AGE: Years 47 | Months 10 | Days 12 | If less than one day: hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Seamen. American Can Co.
11. Industry or business

MOTHER / FATHER
12. Name Henry Batching
13. Birthplace Md.
14. Maiden Name Anna Broken (Bratley)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25. 1948 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location Irvington Road.

18 (a) Funeral director J. WENDELL DIPPEL
(b) Address 312 S. Highland Ave

19 (a) SEP 24 1948 (b) Registrar Huntington Williams, M.D.
Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 21- 1948 at 1:00 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death: Myocardial infarction? — Duration 1 min

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary disease

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature H. T. Wilson M. D.
Address BCH Date signed 9-22-48

VS (55)

Please write carefully. Typewriter preferred. Signatures: please write the causes of death clearly and legibly.

Asl 667078

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667078 Registered No. 82

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince
(c) City or town Capitol Edgewood
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Horton
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-3-22

8. AGE: Years	Months	Days	If less than one day: hr.	min.
25	11	21		

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Bus Driver
11. Industry or business

FATHER
12. Name John Horton
13. Birthplace Va

MOTHER
14. Maiden Name Charlie Bosley
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 24/48 (month) (day) (year)
(c) Cemetery or crematory Bensley Cem
Location Hillsville Va

18 (a) Funeral director Ellyn Funeral Home
(b) Address 2008 Orleans St
Huntington Hotel

SEP 24 1948 (Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1948 at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1948 to 9-24 1948, and that I last saw him alive on 9-24 1948

Immediate cause of death Bulbar paralysis, acute — Duration 2 days
Due to Myasthenia Gravis — 3 years
(MYASTHENIA GRAVIS)
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Graham E. Sprague
Address Johns Hopkins Hospital Date signed 9-24-48

VS 150

CERTIFICATION APPROVED BY 667079

Hiram Woodward M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860

667079
Registered No.

1. PLACE OF DEATH (MEDICAL CERTIFICATE)
(a) Baltimore City, Maryland
(b) Street address Calow & Wilkins Ave
(c) Hospital or institution:
St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 Summit Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Donnell
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/13/1850
8. AGE: Years 85 | Months 1 | Days 10 | If less than one day: hr. min. 1860

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Bryan O'Donnell
13. Birthplace U.S.A.

MOTHER
14. Maiden name Anne Marie Cusick
15. Birthplace

16 (a) Informant Edgar O'Donnell
(b) Address 1813 Summit Ave

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof Nov 27-40 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore City

18 (a) Funeral director John R. Young
(b) Address 1st Aletheia md 27

19 (a) 9/2/40 (Date rec'd by Registrar)
Thurlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23/ 1940 at 8:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/30 1940 to 11/23 1940, and that I last saw him alive on 11/23 1940. Immediate cause of death: Cardiac Failure

Duration: 2 hrs

Due to Acute Dilatation of Heart

Due to Exhaustion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Fall - slipped & fell to floor (inside)

23. Signature
Address Date signed 11/23/40

VS 150

667080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 667080

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 S. Smallwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2143 W. Baltimore St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Paul George Dittrich

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma A. Dittrich
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr) August 20, 1895

8. AGE: Years 53 | Months 1 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county and State)

10. Usual Occupation Butcher
11. Industry or business self

FATHER
12. Name Edward M. Dittrich
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Bretschneider
15. Birthplace Germany

16 (a) Informant Mrs. Emma A. Dittrich
(b) Address 2143 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director George J. Schwab
(b) Address 2101 Frederick Ave

19 (a) SEP 25 1948 (b) Registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1948, at 7:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to 9/24 1948 and that I last saw him alive on 9/23 1948

Immediate cause of death: Coronary Thrombosis — Duration: 4 mos
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. A. Reiter
Address 2145 W. Balto St. Date signed 9/24/48 M.D.

X

667081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

667081 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2550 Aisquith St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME IDA L. TALBOTT

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 27, 1869

8. AGE: Years 78 | Months 8 | Days 24 27 | If less than one day: hr. min.

9. Birthplace: Baltimore County, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: John Miller
13. Birthplace: Baltimore County, Md.

MOTHER
14. Maiden Name: Frances Miller
15. Birthplace: Baltimore County, Md.

16 (a) Informant: James Talbott
(b) Address: 2219 Aiken St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/48 (month) (day) (year)
(c) Cemetery or crematory: Protestant Methodist
Location: New Market, Baltimore Co., Md.

18 (a) Funeral director: William Cook, Inc
(b) Address: 1217 St. Paul St.

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1948, at 5:53 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 - 1946 to 9-23 - 1948, and that I last saw her alive on 9-18 - 1948

Immediate cause of death	Duration
Organic Heart Disease	unknown
Due to	
Due to	
Other Conditions Diabetis	unknown

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Chester Kilmon
Address 253 E Edmondson Ave Date signed 9-24-48

VS 150

9 C

667082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 667082

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Old Spring Ave
(c) ~~Hospital or~~ institution: " " Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 Brentwood Ave (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Robert J. Lytle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married,~~ widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Grace E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12th 1866

8. AGE: Years 82 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name (Unknown) Lytle
13. Birthplace "

MOTHER
14. Maiden Name Sarah V. Cassell
15. Birthplace "

16 (a) Informant Robert B. Lytle
(b) Address 23 E. Susquehanna Ave Tow

17 (a) Burial (Burial, ~~cremation,~~ or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto.
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23rd 1948, at 5:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1948 to 9-23 1948 and that I last saw h~~im~~ alive on 9-23 1948.

Immediate cause of death: Generalized Arteriosclerosis. — Duration: 15 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Kerman, M.D.
Address 3803 Edmondson Ave Date signed 9/24/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

667083 CERTIFICATE CORRECTED 9-1-50 ✓ 667083

JL - 118905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 E. Lorraine Ave.-18 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amos S. Stewart or S. Amos Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ella Jane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 16, 1871

8. AGE: Years	Months	Days	If less than one day
77	6	6	hr. min.

9. Birthplace Md. (Maryland (S.)) (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Samuel Stewart
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Herrman
15. Birthplace Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory Dulaney
Location

18 (a) Funeral director Wilson Roth, Inc
(b) Address 217 E. Read St.

19 (a) SEP 25 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Sept. 22 1948 at 11.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1948 to Sept. 22 1948 and that I last saw him alive on Sept. 22 1948

Immediate cause of death CVA — Duration mins.

Due to HCVD Exhaustion — yrs

Due to — yrs

Other Conditions Nephritis Syphilis
(Include pregnancy within 3 months of death)

Date of operation None performed

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon Erith M. D.
Address Balt. City Hosp. Date signed 9/23/48

VS 150

667084 4P-19826 BALTIMORE CITY HEALTH DEPARTMENT ✓ 667084

CERTIFICATE OF DEATH 159

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County .....
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1229 ST. JAMES ST
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country .....

3 (a) FULL NAME BABY "LILLIE MAE" HOLT

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: FEMALE | 5. Color or race: COLORED | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 9-17-48

8. AGE: Years — | Months — | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE Md.
(Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace .....

MOTHER
14. Maiden Name .....
15. Birthplace .....

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory .....
Location .....

18 (a) Funeral director .....
(b) Address .....

19 (a) SEP 25 1948 (b) Huntington Williams, MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 20 1948, at 8:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1948 to 9-20 1948, and that I last saw HER alive on 9-20 1948.

Immediate cause of death — Duration

Due to Prematurity

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature A. C. Fang M. D.
Address Johns Hopkins Hosp Date signed 21 Sept 48

VS 150

Physicians: please write the causes of death clearly and legibly. The information requested is important.

BC-48-20239 ✓

G67085

JL - 122882

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

Registered No. G67085

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2645 Boone St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hinton- Romaine

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 11, 1948

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Andrews
13. Birthplace Ga.

MOTHER
14. Maiden Name Romaine Harris
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9-13-48 9am (month) (day) (year)
(c) Cemetery or crematory B.C.H. Crematory
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Huntington-Williams Mo

MEDICAL CERTIFICATION

PM

20. DATE OF DEATH Sept. 12 1948, at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 1948, to Sept. 12 1948, and that I last saw him alive on Sept. 12 1948.

Immediate cause of death: Congenital Heart abnormalities — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Congenital Heart + abnormalities

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W M Cox

Address 4940 Eastern Ave Date signed 9/15/48 M. D.

VS :50

X

G67086

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G67086

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles St.
(c) Hospital or institution: Doctors Hospital Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Owings Mills (If outside city or town limits write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gibbons, Myrtle Myrtle F. Gibbons

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 29, 1894

8. AGE: Years	Months	Days	If less than one day
53	8	25 2/6	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Paul L. Lind
13. Birthplace Md.

MOTHER
14. Maiden Name Lula Witz
15. Birthplace Md.

16 (a) Informant Paul C. Linde
(b) Address 3026 Marlen Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Little
(b) Address 4101 E. Edmondson Ave.

19 (a) SEP 25 1948 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1948, at 3 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to Sept 24 1948, and that I last saw her alive on Sept 3 1948.

Immediate cause of death: Cerebral Accident
Due to: Hypertensive Cardio Vascular Disease — Duration: 1941
Due to: Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature W. Steadle
Address 314 - 00 Dutch Rd. Date signed 9/24/48.

VS 150

667087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 667087

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. TYPEWRITER, WITH NON-FADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 Lyndhurst St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Lyndhurst St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion P. Rippel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Conrad D. Rippel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1868

8. AGE: Years 79 | Months 8 | Days 29 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name George Foster
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Courtney
15. Birthplace England

16 (a) Informant Mr. Conrad D. Rippel
(b) Address 306 Lyndhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Ext. Balto. Md.

18 (a) Funeral director Harry A. Luckett
(b) Address 4101 Edmondson Ave.

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Washington Millard, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23/48 19 , at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Sept 23 1948, and that I last saw her alive on 23 Sept 1948.

Immediate cause of death Metastasis from Carcinoma of left Breast — Duration 4 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos. H. Zimmerman M. D.
Address 2058 Harlem Ave. Date signed 24 Sept 48

VS 150

667088

BC- F 81748

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 74a

Registered No. 667088

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Green Sts.
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3215 White ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gilbert Forrester Jr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 7, 1943

8. AGE: Years	Months	Days	Less than one day
5	1	17	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Gilbert C. Forrester Sr
13. Birthplace Maryland

MOTHER 14. Maiden Name Charlotte G. Rankin
15. Birthplace Maryland

16 (a) Informant Gilbert C. Forrester Sr.
(b) Address 3215 White Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director John A. Moran
(b) Address 3000 E. Balt. St.

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1948, at 6 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1948, to 9-22 1948, and that I last saw him alive on 9-24 1948.

Immediate cause of death Leucopenia and anemia

Due to Acute Leukemia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G J Krauss for [illegible] M. D.
Address [illegible] Date signed 9-24-48

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

~~67089~~

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170c

Registered No. 667089

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital 154

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4022 Belle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALEXANDER ELLSWORTH STEHLEY

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-18-9509

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Nettie T. Stehley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13 1888

8. AGE: Years 59 | Months 10 | Days 11 | If less than one day: hr. min

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Pipe Fitter

11. Industry or business B & O R.R.

FATHER 12. Name Samuel Stehley

FATHER 13. Birthplace W. Virginia

MOTHER 14. Maiden Name Mary A. Fergusson

MOTHER 15. Birthplace Norfolk Va.

16 (a) Informant: Nettie T. Stehley

(b) Address 4022 Belle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27 1948 (month)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md

18 (a) Funeral director Harry A. Kunkel

(b) Address 4204 Ridgewood Ave.

19 (a) SEP 25 1948 (Date received by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24, 1948, at 6.50 A M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock due to multiple fractures

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-24-48 at approx. 6.30 A. M.

(b) Where did injury occur? North & Pennsylvania Ave

(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no

(d) Means of injury pedestrian struck by truck & auto

23. Signature [signature] M.D. Medical Examiner

Date signed September 24, 1948

VS 151

Important: Physicians: please write the causes of death clearly and legibly.

167090 Dr Hauck

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 167090

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave
(c) Hospital or institution: Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 821 N 36 St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas A Huser
3 (b) If veteran, name war
3 (c) Social Security Account No. 218-07-7686

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Annie L
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 28-1871
8. AGE: Years 76 | Months 9 | Days 25 | If less than one day hr. min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Stereotyper
11. Industry or business News Paper

FATHER
12. Name Nicholas Huser
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs Annie Huser
(b) Address 821 N 36 St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Md
18 (a) Funeral director Frank H Seiler
(b) Address 814 N 36 St.
19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Cartington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1948 2:15 PM
21. I certify that death occurred on the date above stated; that I attended deceased from July 1948 to Sept 23 1948 and that I last saw him alive on Sept 23 1948

Immediate cause of death: Cerebral Hemorrhage
Due to: Cerebral Sclerosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 4 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm C Hauck MD
Address 1727 W Lanvale St Date signed Sept 24 1948

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

67091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. 67091

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1426 Harlem Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Manns
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	W.

6 (b) Name of husband or wife Robt.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-1883

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65	3			

9. Birthplace Lancaster Co. Va (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Robt. Henderson
13. Birthplace Lancaster Co. Va.

MOTHER
14. Maiden Name Rebecca —
15. Birthplace Lancaster Co. Va.

16 (a) Informant Hattie Manns
(b) Address 1426 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Arbutus, Md

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Pleasant Hill Ave Baltimore, Md

19 Date SEP 25 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1948 at 4:28 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1948 to Sept 22 1948 and that I last saw her alive on Sept 22 1948.

Immediate cause of death Cerebral hemorrhage.
Due to Hypertension. Chronic arterio sclerotic disease.
Due to —
Other Conditions (Include pregnancy within 3 months of death)

Duration: —

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1118 Edmondson Ave M. D.
Date signed 9-27-48

VS 150

667092 M. - 9506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667092

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Pitts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1878

8. AGE: Years 69 | Months 10 | Days 22 | If less than one day: hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Pitts
13. Birthplace Va.

MOTHER
14. Maiden Name Mattie ?
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelly
(b) Address 1303 Pleasant Man

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1948 at 2.15 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1948 to Sept 23 1948. and that I last saw h im alive on Sept. 23 1948.

Immediate cause of death Pulmonary edema. — Duration 2 days

Due to Hypertensive Arteriosclerotic Cardiovascular Disease. — 5 yrs.

Due to

Other Conditions Bronchopneumonia slight, bilat. (Including pregnancy within 3 months of death) — 5 days

Date of operation

Major findings of operation:

of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature William H. Kuhns M.D.
Address Balto City Hosp Date signed 23 Sept 48

VS 150

667093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

667093 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or ~~institution~~: South Balto Genl Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 9 2 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 452 Andrae St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anton M. Rasmussen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Martha L.

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Mar 3 1872

8. AGE: Years 76 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Denmark
(Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business Varies

FATHER
12. Name (Unknown) Rasmussen
13. Birthplace Denmark

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Frederick A. Rasmussen
(b) Address 452 Andrae St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director William Cook Inc.
(b) Address 1817 St. Paul St.

19 SEP 25 1948 (Date rec'd by registrar) (b) Washington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 22 1948 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1948 to 9/22 1948 and that I last saw him alive on 9/22 1948.

Duration

Immediate cause of death UREMIA
LOBAR PNEUMONIA, RIGHT & LEFT LOWER LOBES
Due to CHRONIC NEPHRITIS
Due to ARTERIOSCLEROSIS
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ACCIDENT
(b) Date of occurrence 9/15/48 at M
(c) Where did injury occur? BALTIMORE, MD.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME While at work?
(Specify type of place)
(e) Means of injury? FELL DOWN STEPS

23. Signature Samuel B. Scalia M. D.
Address 20 E. Balto St. Date signed 9/25/48

To be approved by Chief Medical Examiner

Cause of death must be carefully supplied. The causes of death clearly and legibly.

67094 — over — 67094

BALTIMORE CITY HEALTH DEPARTMENT — Registered No. 67094

CERTIFICATE OF DEATH 121a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 137 N. Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 137 N Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie B. Holste

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Arnold —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) October 18 1877

8. AGE: Years 71 | Months 11 | Days 12 | If less than one day hr. min

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name George Holste, HERGET
13. Birthplace Balto Md

MOTHER
14. Maiden Name Anna Eichorn
15. Birthplace Unknown

16 (a) Informant Miss Mildred Holste
(b) Address 137 N Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Olivet St

18 (a) Funeral director J. HEERMANN & SON
(b) Address 6067 HARFORD Rd

19 SEP 25 1948 (Date filed by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1948, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30- 1948 to 9-24- 1948, and that I last saw her alive on 9-24- 1948.

Immediate cause of death Uremia — Duration 2 days
Due to Arteriosclerotic C.V. disease — 2 years
Due to —
Other Conditions Chronic nephritis
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Benj. B. Moore, M. D.
Address 4482 N. Charles Ave Date signed 9-25-48

VS 150

667095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

Registered No. 667095

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Good Samaritan Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Kerry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT GRINER Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Georgia (town, county, and state)

10. Usual Occupation Auto Mechanic

11. Industry or business

FATHER
12. Name Robert Griner Sr.
13. Birthplace Ga.

MOTHER
14. Maiden Name Parkerson
15. Birthplace

16 (a) Informant Robert Griner Jr III
(b) Address 336½ 15. Ave. Newark, N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48.

(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave. Huntington, W. Va.

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep. 22 1948, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Glomerulo Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 23 Sept 48

VS 151

667096

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 467

667096 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University of Md. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Kenyon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANK S. RUTTER

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1869

8. AGE: Years	Months	Days	If less than one day
79	1	5	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Hand Painter

11. Industry or business Purnell Art Galleries

FATHER
12. Name Joseph H. Rutter
13. Birthplace Md.

MOTHER
14. Maiden Name Christina Gill
15 Birthplace Maryland

16 (a) Informant Mrs. Harry G. Rutter, sister-in-law
(b) Address 3401 Kenyon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Christopher Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23-1948, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21-1948 to 9-23-1948, and that I last saw him alive on 9-23-1948.

Immediate cause of death Respiratory Failure - Shock
Conditions Failure - Shock
Etiology Failure
Due to malnutrition, anemia,
Cachexia
Due to Carcinoma of Rectum
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature William A. Warthin M D
Address Univ. Hosp. Date signed 9-23-48

VS 150

Please write causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The especially important.

667097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 667097

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 71, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dora B. Weil

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife None.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 4, 1864

8. AGE: Years 84 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER 12. Name Moritz H. Weil (D)
13. Birthplace Germany

MOTHER 14. Maiden Name Betty Gump (D)
15. Birthplace Germany

16 (a) Informant Miss Dora B. Weil
(b) Address Marlborough Apts.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 25 1948 (Date received by registrar) (b) Huntington Williams, M.D. Address 33 W. Calvert St. Balto 18

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1948, at 2:39 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1948 to Sept 24 1948, and that I last saw her alive on Sept 24 1948.

	Duration
Immediate cause of death: Intestinal Obstruction	22 days
Due to: Adenocarcinoma of Sigmoid (resected)	
Due to: Post operative complications.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George P. Thomas M. D.
Address 33 W. Calvert St. Balto 18
Date signed 9-24-48

VS :50

667098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G67098

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4106 The Alameda
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4106 The Alameda
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Mary Thompson

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Royal Oak, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Thompson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Jean Feeser
(b) Address Taneytown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory Spring Hill Cem.
Location Easton, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Sept. 1948 at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammerly M.D.
Medical Examiner.
Date signed 24 Sept. 48

VS 191

667099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

667099 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 Hollins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1302 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Leaverton Cross

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Geo. Wilbur Cross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21st 1870

8. AGE: Years	Months	Days	If less than one day
78	3	3	hr. min.

9. Birthplace Kent Co. Maryland (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Charles Long
13. Birthplace England

MOTHER
14. Maiden Name Sarah Hopkins
15. Birthplace Harford Co. Maryland

16 (a) Informant Mrs Addie Lee
(b) Address 2010 Parish St Phila. Pa.

17 (a) Sept 27 1948 (b) Date thereof (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Chester Cemetery
Location Kent Co. Maryland

18 (a) Funeral director W. W. Lewis Inc.
(b) Address 430 Edmondson Ave.

19 SEP 25 1948 (Date received by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24-48 19 at 6:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23-48 19 to 9-24-48, and that I last saw her alive on 9-24 19 48.

Immediate cause of death Coronary Thrombosis — Duration 4 days
Due to Generalized arteriosclerosis —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. B. Schreiber M.D. M. D.
Address 543 S. Fulton Ave Date signed 9-25-48

CONTRADICTING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

667100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667100 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 Belgian ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 Belgian ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA A. GILES

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ----

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edward Hart Giles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1861

8. AGE: Years 87 | Months 6 | Days -- | If less than one day hr. min.

9. Birthplace Westfield, N.J.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John Henry Urmstone
13. Birthplace New Jersey

MOTHER
14. Maiden Name Emma Woods
15. Birthplace New Jersey

16 (a) Informant Mrs. Amy M. Searls
(b) Address 801 Belgian ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory St. John's Episcopal
Location Old York Rd. & Greenmount ave.

18 (a) Funeral director Chas. E. Evans & Son Inc
(b) Address 118 W. Mt. Royal Ave

19 (a) Date filed by registrar SEP 27 1948 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Sept 24 1948.
and that I last saw h[illegible] alive on Sept 23 1948.

Immediate cause of death [illegible] Duration 10 days
Due to Hypertension 3 years.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Herbert M. Frantz, M.D.
Address 2824 St. Paul St Date signed Sept 24-48

VS 150

Information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

667101

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 667101

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Forest Hill
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Samuel Whitaker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Wh | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 91 | Months: 0 | Days: 28 | If less than one day: hr. - min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Farmer

11. Industry or business

FATHER 12. Name: Joshua Whitaker
13. Birthplace: Forest Hill Maryland

MOTHER 14. Maiden Name: Virginia Walker
15. Birthplace: Maryland -

16 (a) Informant: Elva Whitaker
(b) Address: Forest Hill Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28 48 (month) (day) (year)
(c) Cemetery or crematory: Mt Nathan Memorial Park
Location: Cooptown Harford Co

18 (a) Funeral director: Charles E Hunt
(b) Address: Jarrettsville Md

19 (a) 26 1948 (b) (Date rec'd by registrar) Registrar

Funeral Director Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1948, at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1948 to 9-24 1948, and that I last saw h (illegible) alive on 9-24 1948

Immediate cause of death: Pulmonary embolism - origin - Iliac veins (?)
Due to
Due to
Other Conditions: Diabetes mellitus - Arteriosclerotic C.V. disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pulmonary embolism -

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature: L. S. Davis MD
Address Baltimore Md Date signed 9-25-48 M. D.

111a

667102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

667102 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster, Md.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Charles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Columbus Shean

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	widowed

6 (b) Name of husband or wife Mary C. Shean
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) not known

8. AGE: Years	Months	Days	If less than one day: hr.	min.
84	?	?		

9. Birthplace Westminster Carroll Co. Md (Town, county and state)
10. Usual Occupation retired laborer
11. Industry or business

FATHER
12. Name Dennis Shean
13. Birthplace Maryland

MOTHER
14. Maiden Name ? Not known
15. Birthplace

16 (a) Informant Mrs. Laura Shean
(b) Address Charles St. Westminster Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Ellsworth Cem.
Location Westminster Md.

18 (a) Funeral director J. E. Myers. D.
(b) Address Westminster Md.

SEP 26 19 48 (a) (b)
(Date rec'd by registrar) Westminster, Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1948, at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1948, to 9-25-48 19 , and that I last saw him alive on 9-25-48 19

Immediate cause of death
Arterio-sclerosis C.V. disease

Due to Contributing factors

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard D. Coon, M. D.
Address Date signed 9-27-48

VS 150

667103

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G 67103

512 G67103

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Towson 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sheppard Pratt Hospital
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Dr. Ross McClure Chapman

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mrs. Marion C. Chapman
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) July 13, 1881

8. AGE: Years	Months	Days	If less than one day
67	2	11	..... hr. ..... min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation Supt. Sheppard Pratt Hosp
11. Industry or business -

FATHER
12. Name Mr. Eugene Chapman
13. Birthplace New York

MOTHER
14. Maiden Name Agnes McClure
15. Birthplace New York

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Henry Watkins Sons Co
(b) Address Fork Rd. & Reisterstown Ave

SEP 26 1948
(Date received by registrar)

(b) 6
(Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1948, at 10:46 P M

21. I certify that death occurred on the date above stated; that I attended deceased from September 11 1948 to September 24 1948, and that I last saw him alive on 1948.

Immediate cause of death — **Duration**

(a) Carcinoma of prostate — 1 yr. 11 mos.
Due to
(b) Metastases to bones generalized — 4 mos.
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature John R. Smith, Jr. M.D.
Address Union Memorial Hosp., Date signed 9/27/48

G67104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G67104

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 Belle Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Harry Aronoff

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose Mark
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. May 6 1896

8. AGE: Years	Months	Days	If less than one day
52	4	18	hr. min.

9. Birthplace Brooklyn N.Y.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Merchant

FATHER
12. Name Samuel Aronoff
13. Birthplace Russia

MOTHER
14. Maiden Name Rebeccia Bellnowsky
15. Birthplace Russia

16 (a) Informant Rose Aronoff
(b) Address 3820 Belle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof – – (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1114-16 W. Baltimore Avenue

26 1948
(a) (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 19 48 at 1.30p M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 1947 to Sept 24 1948 and that I last saw him alive on Sept 21 1948

Immediate cause of death Coronary thrombosis — Duration Immediate death

Due to Arteriosclerosis — 3 years +

Due to –

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Alan Bernstein M. D.
Address 1109 N. Calvert St Date signed 9/27/48

VS 152

667105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

667105 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 416 E Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Lipsy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Israel
13. Birthplace Russia

MOTHER
14. Maiden Name Jennie
15. Birthplace Russia

16 (a) Informant Charles H. Lipsy
(b) Address 416 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mtg Carmel

18 (a) Funeral director Jack Kewing Inc
(b) Address 2460 Eutaw Place

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Sept. 1948 at 3:25 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cirrhosis of Liver with Jaundice & hepatomegaly.
Due to Alcohol

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr M.D. Medical Examiner
Date signed 25 Sept. 1948

VS 181

667106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 141 F

667106 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 Fleet St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPHINE HOFT Hoft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
20				

9. Birthplace Newyork NY (Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business

FATHER
12. Name Herman
13. Birthplace Newyork

MOTHER
14. Maiden Name Rose
15. Birthplace Newyork

16 (a) Informant Herman Hoft
(b) Address Kings Park N. Y

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 206 Eutaw Place Baltimore MD

SEP 26 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1948, at 6:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Septicemia
Acute Peritonitis
Due to (b) Puerperal Abortion

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-8-48 at ? M.
(b) Where did injury occur? 1718 Fleet Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Criminal abortion

23. Signature Earl C Kruger M.D. Medical Examiner
Date signed 9/24/48

VS 151

Please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 5-9-89

BALTIMORE CITY HEALTH DEPARTMENT

667107 Registered No. 667107

CERTIFICATE OF DEATH 469

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3220 Strickland St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 70
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3220 Strickland St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALFRED L. DONALDSON

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	218-22-3553	male	white	married

6 (b) Name of husband or wife Bertha E. Donaldson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 20, ~~1879~~ 1882

8. AGE: Years	Months	Days	If less than one day: hr.	min.
(89) 66	0	4		

9. Birthplace Chester, Pa. (Town, county, and state)
10. Usual Occupation Stationary Engineer
11. Industry or business Bd. of Edu.-City of Balto.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Mr. Wm. P. Webb
(b) Address 13 S. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Registrar
Date rec'd by registrar SEP 26 1948
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24, 1948, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1946 to 9/24 1948.
and that I last saw h[illegible] alive on 9/23 1948.

Immediate cause of death Carcinoma of pancreas — Duration 2 mos

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Sept 13, 1948

Major findings of operation: Ca of pancreas, metas- tasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Albert L. Donaldson M.D.
Address 1030 Wilbur Date signed 9/28/48

X

67108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54C

Registered No. 67108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Frederick (If outside city or town limits, write RURAL and give town)
(d) Street No. Wilson Place (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME C. Truman Lippy

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Pauline C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/3/05

8. AGE: Years	Months	Days	If less than one day
43	4	22	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Insurance Agent
11. Industry or business Insurance Co.

FATHER
12. Name Irving Lippy
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Kelly
15. Birthplace Md.

16 (a) Informant Wife
(b) Address Frederick Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director W. R. Eicherson, Sons
(b) Address Frederick Md

19 (a) Filed SEP 29 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1948, at 9:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1948, to 9/25 1948, and that I last saw him alive on 9/25 1948.

Immediate cause of death	Duration
Malignancy of Brain	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9/24/48
Major findings of operation: Malignancy of brain
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Nicholas Mallis
Address University Hosp Date signed 9/25/48

VS 150

667109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

667109
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 W. Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: GEORGE PEARSON

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/5/1943

8. AGE: Years 4 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name James Pearson
13. Birthplace Winnsboro, S.C

MOTHER
14. Maiden Name Charlotte Glenn
15. Birthplace Winnsboro, S.C.

16 (a) Informant: Charlotte Pearson (M)
(b) Address 1308 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month)

(c) Cemetery or crematory St. Johns
Location Winnsboro, S.C.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

SEP 26 1948 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1948 at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Ruptured Spleen
Lacerations of Pancreas
Perforating Wounds of Intestines.

Due to

Other Conditions Healing Fracture of Left Femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-8-48 at Approx. 3:30 P.M.
(b) Where did injury occur? In front of 1316 W. Lafayette Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by Taxicab

23. Signature Edward L. Kaye M.D.
Medical Examiner.

Date signed 9-25-48

VS 1st

667110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

667110 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County U. L. A.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Jenkins Manor (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Dohme (Grace H. Dohme)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Justus Dohme
6 (c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr) 9/28/1880
8. AGE: Years 68 | Months 11 | Days 29 | If less than one day hr. min.
9. Birthplace Frederick Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business —

FATHER
12. Name Malachy Etzler
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Megley
15. Birthplace Md.

16 (a) Informant Ralph Justus Dohme
(b) Address 7310 Hamilton Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof SEP 28 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn, Balto Co Md
18 (a) Funeral director E. Ellis Lamograux
(b) Address 4510 Liberty Heights Ave
19 (a) (b) Registrar
(Date rec'd by registrar) Washington Hollowell, M.D.

VS 10

SEP 26 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 1948, at 11:4 M
21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1948 to 9/25, 1948 and that I last saw h[illegible] alive on 9/26 1948

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Primary carcinoma of liver (cholangioma)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-14
Major findings of operation: as above
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney J. Venable, Jr. M.D. 40
Address St. Agnes Hospital Date signed 9-25-48

X

667111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Bi. Chaplegate Lane
(c) Hospital or institution: Pinecrest Sanatarium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince Georges
(c) City or town Mt. Rainier (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3103 - Bunker Hill Rd. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME John J. Knowles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65 ?			hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)

10. Usual Occupation Telegraph Retired

11. Industry or business

FATHER
12. Name David D Knowles
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Mary Hogan
15. Birthplace Baltimore, Md.

16 (a) Informant Charles P. Knowles
(b) Address 97 - Galveston St. S.W. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 - 29 - 48 (month) (day) (year)
(c) Cemetery or crematory Holy Rood Cemetery
Location Wisconsin Ave. Wash. D.C.

18 (a) Funeral director Wm. J. Malley
(b) Address 3200 - R.I. Ave - Mt. Rainier, Md

19 SEP 26 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26 1948, at 7.55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1948, to Sept. 26, 1948, and that I last saw him alive on Sept. 25 1948.

Immediate cause of death	Duration
CARDIAC Failure	24 hrs.
Due to MYOCARDIAL Degeneration	?
Due to ARTERIOSCLEROSIS	?
Other Conditions CHRONIC BRONCHITIS	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melvin N. Borden M. D.
Address 2030 W. Fayette St Date signed 9/20/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The name of informant should be carefully supplied.

G67112 ✓ G67112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 30 N. East Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 30 N. East Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alfred A. Del Ciello

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-0975

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose Del Ciello
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 1st 1888

8. AGE: Years	Months	Days	If less than one day
59	11	22	23 hr. min.

9. Birthplace Posso Lanciano Italy (Town, county, state)
10. Usual Occupation Forman
11. Industry or business Empire Contr. Co.

FATHER 12. Name Felice Del Ciello
13. Birthplace Italy

MOTHER 14. Maiden Name Marianna Martello
15. Birthplace Italy

16 (a) Informant Rose M. Del Ciello (Wife)
(b) Address 30 N. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 322 S. High St.

19 (a) (Date rec'd by reg.) SEP 26 1948 (b) Huntington Williams, M.D.

VS-199

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1948, at 7:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1948 to Sept 23 1948, and that I last saw h[illegible] alive on Sept 23 1948

Immediate cause of death Glandular Carcinoma — Duration 3 months

Due to Carcinoma of Colon — 2 yr.

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation April 1947

Major findings of operation Carcinoma Colon

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?
(e) Means of injury

23. Signature Harry Jardiner
Address 432 Belair Rd Date signed Sept 24, 1948

Edna Kirkpatrick X

67113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Eastern Ave
(c) Hospital or institution Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Kimball
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 29 1879

8. AGE: Years 69 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER | FATHER
12. Name Felix Kimball
13. Birthplace Annapolis Md.
14. Maiden Name Annie Faust
15. Birthplace Annapolis Md

16 (a) Informant Laura A. Kimball
(b) Address 814 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director William Cook
(b) Address 1217 St. Paul St.

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26 1948, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1948 to 9/26 1948, and that I last saw her alive on 9/25 1948.

Immediate cause of death Cardiac failure
Arteriosclerotic Heart Disease
Coronary thrombosis

Duration

Due to Coronary - Cause of death
Left Hemiplegia
SADDLE Embolus
Due to Aorta

Other Conditions Accessory Spleen
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: — Same - see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D.W. Winter M.D.
Address Church Home & Hosp. Date signed 9/26/48

US 153

67114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 927

67114 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DON
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 N. Paca (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME John W. Cooke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 4 1866

8. AGE: Years 82 | Months 2 | Days 9 | If less than one day hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Terry Cooke
13. Birthplace Ireland

MOTHER
14. Maiden Name Helen (Unknown)
15. Birthplace Md.

16 (a) Informant: John T. Murphy
(b) Address 2315 Ashburton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Pratt St.

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23/48 19 .. at 6:15 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature John R. Weirs M.D. Medical Examiner
Date signed 9/24/48

VS 151

G67115

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 120

G67115
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk Dr & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Garland GAY

3 (b) If veteran, name war World War II

3 (c) Social Security Account No. 219-10-7738

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1925

8. AGE: Years	Months	Days	If less than one day
22	9	1	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Iceman

11. Industry or business Ice business

FATHER
12. Name Kendall Gay
13. Birthplace Va.

MOTHER
14. Maiden Name Connie Wright
15. Birthplace N.C.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal **(b) Date thereof** 9/27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Quaker Ridge
Location N. C.

18 (a) Funeral director Williams Park Inc
(b) Address 1217 E. Pratt St

19 (a) SEP 27 1948 **(b)** Hunting for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26, 19 48 at 8:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 5, 19 48 to Sep 26, 19 48, and that I last saw him alive on Sep 26, 19 48.

Immediate cause of death	Duration
Glomerulo-nephritis, subacute, with uremia	unkn.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Vaccaro M. D.
Address Marine Hospital Date signed 9/26/48

V S 150

667116

BALTIMORE CITY HEALTH DEPARTMENT

BC- 48-18725 CERTIFICATE OF DEATH 159

Registered No. 667116

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 Division St
(c) Hospital or institution: Provident Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 11 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5705 Belle Grove Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sandra Day #1

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fe | 5. Color or race negro | 6 (a) Single, married, widowed, or divorced. S-n-g/c

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/30/48

8. AGE: Years | Months | Days | If less than one day 11 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation New Born

11. Industry or business

FATHER
12. Name Julius Day
13. Birthplace Langston VA

MOTHER
14. Maiden Name Marcelline Wharton
15. Birthplace Baltimore Md

16 (a) Informant Mrs Marcelline Day
(b) Address 5705 Belle Grove Rd

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School SEP 23 1948
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 SEP 27 1948 (Date filed by registrar) (b) Huntington Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1948 at 2:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1948 to 8/30 1948. and that I last saw h[illegible] alive on 8/30 1948.

Immediate cause of death Immaturity 2 hrs 11 hrs. Duration

Due to ?

Due to

Other Conditions Aspiration of mucus?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Provident Hosp Date signed 8-2-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667117

Y8. 11872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

667117

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 16-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 16 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1218 N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorethea Cornish

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	N	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/16/48

8. AGE: Years | Months | Days | If less than one day 16 hr. 47 min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation N' Born infant

11. Industry or business

FATHER
12. Name Ramond Cornish
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Martha Veney
15. Birthplace Baltimore Md

16 (a) Informant Mrs Martha Mason
(b) Address 1218 Fremont ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Sch SEP 23 1948
Commissioner of Health

18 (a) Funeral director
(b) Address SEP 27 1948

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/17 1948, at 12:47 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16 1948 to 7/17 1948.
and that I last saw h[illegible] alive on 7/17 1948

Immediate cause of death
Atelectasis ?

Due to Birth Trauma and respiratory distress

Due to Traumatic hemorrhage — complicate to coma

Other Conditions
Premature
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evan O'Neill Kane M.D.
Address Provident Hosp. Date signed 7/18/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Type or print all items. Every item of information should be carefully supplied.

VS 150

667118-3C-48-1958

BALTIMORE CITY HEALTH DEPARTMENT ✓ 667118

CERTIFICATE OF DEATH 160a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 N Fulton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest Woodrow Wilbon Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/31/48

8. AGE: Years	Months	Days	If less than one day
		1	18 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Ward Boy Infant

11. Industry or business

FATHER
12. Name Ernest Woodrow Wilbon
13. Birthplace Greensboro N.C.

MOTHER
14. Maiden Name Frances Gentry
15. Birthplace Dobson N.C.

16 (a) Informant Mrs Frances Wilbon
(b) Address 829 N Fulton Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) SEP 27 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2 1948 at 12½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1948 to 9/2 1948 and that I last saw him alive on 9/2 1948.

Immediate cause of death Massage interna Lendenwirbel site unbestimmt. — Duration

Due to Probably injury at birth or congenital anomaly of spinal cord

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Provident Hospital Date signed 9-2

Johns Hopkins Medical School SEP 23 1948
Commissioner of Health

VS 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67139 48-19057 ✓ 67139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. 67139

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any error, omission or illegible information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 mins
(e) Length of stay in Baltimore (yrs., mos., or days) 21 mins

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 W Saratoga St apt 2 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Smart

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/5/48

8. AGE: Years	Months	Days	If less than one day
			hr. 21 min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Born Dead infant
11. Industry or business

FATHER
12. Name John Smart
13. Birthplace Camden SC

MOTHER
14. Maiden Name Orsinile Esther Moore
15. Birthplace Sussex Co Va

16 (a) Informant Mrs C. Esther Smart
(b) Address 817 W Saratoga St. Apt 2

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School SEP 23 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 27 1948 (b) (Date rec'd by registrar) Carrington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1948, at 9:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1948 to Sept 5 1948, and that I last saw h[illegible] alive on Sept 5 1948.

Immediate cause of death: Pulmonary Atelectasis (Congenital) — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Bonner M. D.
Address 722 N. Fulton Ave Date signed 9/8/48

VS 150

667120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

667120 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens
(c) Hospital or institution St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Russell St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T. Riley

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Lillie

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Aug 28, 1878

8. AGE: Years 72 | Months | Days 25 | If less than one day: hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Railroad

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant (Son) Thomas Riley

(b) Address 3812 Biddison Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/48 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Annapolis Blvd

18 (a) Funeral director John F Kenny Inc

(b) Address 715 Light St

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntingtown Williams, Mgr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1948 at 9 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/21 1948 to 9/23 1948 and that I last saw h/ alive on 9/23 1948.

	Duration
Immediate cause of death CONFLUENT LOBAR PNEUMONIA	
CIRCULATORY COLLAPSE	
Due to KREMLIN	
HYPERTENSIVE CARDIO-	
Due to VASCULAR ARTERIOSCLEROTIC	
HEART DISEASE	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: AS ABOVE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John K Ohlhaus M. D.

Address 1 E Lexington St Date signed 9/24/48

VS 150

667121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

667121 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3658 Buena Vista Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3658 Buena Vista Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche P. Robertson

3 (b) If veteran, name war: –
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife Leonard E. Robertson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16 1889

8. AGE: Years	Months	Days	If less than one day
59	6	8	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Howard Hoover
13. Birthplace Maryland.

MOTHER
14. Maiden Name Margaret Bond
15. Birthplace Maryland

16 (a) Informant Dorothy Robertson
(b) Address 3658 Buena Vista Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave.

18 (a) Funeral director Austin E. Donovan
(b) Address 3638 Roland Ave

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address 2424 St. Paul St

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1948, at 10 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1931 to Sept 24 1948
and that I last saw h[illegible] alive on Sept 24 1948

Immediate cause of death: Coronary Thrombosis — Duration 5 yrs
Due to: Arteriosclerosis — Duration 1 yr
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert M. Foster Date signed Sept 27-48

VS 150

Type or write plainly in permanent ink. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. Especially important.

67122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67122

GM. 123150

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals. 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 812 Harlem Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harvey Payne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 4 1885

8. AGE: Years	Months	Days	If less than one day
63	6	20	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Payne

13. Birthplace MD.

MOTHER 14. Maiden Name Harriett Smith

15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 28 48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Baltimore

18 (a) Funeral director Eugene H. Mayo

(b) Address 825 Harlem Ave

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 24- 1948, at 2.50PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21- 1948, to 9- 24- 1948, and that I last saw him alive on 9- 24- 1948

Immediate cause of death Generalized miliary Tbc

Duration wks

Due to

Due to

Other Conditions post op sub total gastrectomy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: miliary tbc

4 mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jordan Craft M.D.

Address Balt. City Hosp. Date signed 9/25/48

667123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667123

469

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4338 Falls Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4338 Falls Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Tunney, Sr.

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 212-01-4480

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maud B. Tunney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 2, 1880

8. AGE: Years	Months	Days	If less than one day
68	3	22	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Marble Setter
11. Industry or business

FATHER
12. Name William Tunney
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Cashin
15. Birthplace Ireland

16 (a) Informant Mrs. Maud E. Tunney
(b) Address 4338 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 28, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 SEP 27 1948 (Date filed by Registrar) Huntington Williams, M.D. Registrar

VS 153

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH September 24, 1948 at 11.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 71 to 9 24 1948, and that I last saw h[illegible] alive on 9 27 1948.

Immediate cause of death: Carcinoma of head & [illegible] Carcinoma — Duration: [illegible]

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation not done

Major findings of operation:

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon Tulman M.D.
M.D.
Address [illegible] Date signed 9/27/48

667124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

667124 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Baltimore
(c) Hospital or institution:
General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2353 annapolis Road
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Thompson, Helen T.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife James L. Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28-1879

8. AGE: Years	Months	Days	If less than one day
69	1	24/27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name William Wastenhoffer
13. Birthplace Germany.

MOTHER
14. Maiden Name Catherine Dabus
15. Birthplace Germany.

16 (a) Informant Mrs. Gentry Bell.
(b) Address 2353 Annapolis Road.

17 (a) Burial (b) Date thereof Sept. 28-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore Md

18 (a) Funeral director Jennie Cook Sayler
(b) Address 1600 N. North Ave.

19 (a) SEP 27 1948 (b) Investigator Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1948 at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1948 to 9-24 1948, and that I last saw her alive on 9-24 1948.

Immediate cause of death Cerebrovascular hemorrhage left side of brain — Duration 6 days

Due to (Hypertensive arteriosclerosis (gad) heart disease & cardiac enlargement (yrs)

Due to

Other Conditions Chronic arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Dann M. D.
Address W. Balto Gen Hosp Date signed 9-24-48

VS 150

Please write plainly. Physicians: please write the causes of death clearly and legibly. Each question should be carefully supplied. This is especially important.

G67125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G67125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3823 Hudson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3823 Hudson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME G. WALLACE LANGDON

3 (b) If veteran, name war ------
3 (c) Social Security Account No. 212-14-3072

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary L. Langdon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1871.

8. AGE: Years	Months	Days	If less than one day
77	8	0	hr. min.

9. Birthplace Orange Co., N.Y. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ? Langdon
13. Birthplace N.Y.

MOTHER
14. Maiden Name Elizabeth Pye.
15. Birthplace N.Y.

16 (a) Informant Melvin C. Langdon (Son)
(b) Address 3823 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-48. (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location 7225 Eastern Ave.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 901 S. Conkling St.

19 (a) SEP 27 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1948 8:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1948 to Sept 23 1948. and that I last saw h~~im~~ alive on Sept 23 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. J. Davidov M. D.
Address 3218 Eastern ave Date signed 9-24-48

VS 150

667126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

667126

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2623 E. Oliver St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2623 E. Oliver St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Myrtle V. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Van B. Davis Jr.

6 (c) If alive, give age 51 years

7. Birth date of deceased mo., day, yr. June 8, 1899

8. AGE: Years 49 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Feddore Nova Scotia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Alexander Day

13. Birthplace Feddore Nova Scotia

MOTHER 14. Maiden Name Matilda Mitchell

15 Birthplace Feddore Nova Scotia

16 (a) Informant Van B. Davis

(b) Address 2628 E. Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/49 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.

Location Taylor Ave.

18 (a) Funeral director John E. Miller Jr.

(b) Address 2435 E [illegible]

19 (a) SEP 27 1949 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1949, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1946 to Sept 24 1949, and that I last saw h[illegible] alive on Sept 24 1949.

Immediate cause of death [illegible] Myocardial insufficiency

Due to

Due to Carcinoma, Stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

Signature Howard Jordan

Address 1513 N. Milton Ave Date signed Sept 26 49

Howard Jordan M.D.

VS 15

6671 27

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170c

Registered No. 6671 27

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Woodbine
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALLAN HARRISON

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1923

8. AGE: Years 25 | Months 2 | Days 7 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George W. Harrison
13. Birthplace md

MOTHER
14. Maiden Name Margaret Hatfield
15. Birthplace md.

16 (a) Informant: Margaret Hatfield
(b) Address Woodbine, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-48 (month, day, year)
(c) Cemetery or ~~crematory~~ Poplar Springs
Location Poplar Springs, Howard Co. Md.

18 (a) Funeral director C. M. Wells
(b) Address Winfield, Md.

19 (a) (b) Huntington Williams, Registrar

SEP 27 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1948, at 1:15 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull with intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-26-48 at Midnight M.
(b) Where did injury occur? Rt. 40, 1½ miles west of West Friendship, Howard County, Md.
(c) Did injury occur at home, ~~while at work~~, ~~while in~~ in public place? Public While at work? No
(d) Means of injury Auto. & Auto. (Pass.)

23. Signature [signature] M.D.
Medical Examiner
Date signed 9-27-48

Please write the causes of death clearly and legibly.

G667128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G667128 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland ✓

(b) Street address 6420 Reisterstown Road

(c) Hospital or institution: The Seton Institute

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Florida (b) County

(c) City or ~~town~~ Jacksonville (If outside city or town limits, write RURAL and give town)

(d) Street No. 2311 Laurel Road (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Morris D. Wolfson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	white	married

6 (b) Name of ~~husband~~ wife Sarah Goldberg 6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
66	9	10	hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation manufacturers-plumbing supplies

11. Industry or business

FATHER 12. Name Joseph Wolfson

13. Birthplace Russia

MOTHER 14. Maiden Name Dora Lippman

15. Birthplace Russia

16 (a) Informant The Seton Institute

(b) Address 6420 Reisterstown Rd., Balto 15, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27/48 (month) (day) (year)

(c) Cemetery or crematory Jacksonville Florida

Location

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-26 W. North ave

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. The Seton Institute

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27 1948, at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1948, to 9-27 1948, and that I last saw him alive on 9-25 1948

Immediate cause of death Pneumonia — Duration 2 days

Due to

Due to Chronic coronary trad sclerosis 4 yr.

Mercurial poisoning 4 mo.

Other Conditions Complete heart Block 4 mo.

Cerebral injury over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R. L. Meiers M. D.

The Seton Institute Date signed 9/27/48

Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The age is especially important.

667129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 667129

Important: Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address 2532 Boarman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2532 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Philip M Livingston

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-8057

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dora M. Mae Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888.

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Insurance Co

FATHER
12. Name Louis Livingston
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Russia

16 (a) Informant Sidney Livingston
(b) Address 3731 Beehler Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29, (month) (day) (year)
(c) Cemetery or crematory Pikesville Jewish Cemetery
Location Bowleys Lane Herring Run

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 N. North Ave

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1948 at 2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1948 to Sept 27 1948 and that I last saw him alive on Sept 27 1948

Immediate cause of death coronary insufficiency — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ezra Levin M. D.
Address Sinai Hosp - Balt Md Date signed 9-27-48

VS 150

667130

ES- 122159

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

667130 Registered No.

Type or print plainly with indelible pencil. Do not write in the spaces marked for the use of the Registrar. Be sure that every question is answered and that the certificate of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 498 S. Caroline St. (If rural give location)
8 days.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Wiggins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 15, 1912

8. AGE: Years	Months	Days	If less than one day: hr.	min.
36				

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Will Wiggins (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Virginia Jones
15. Birthplace N.C.

16 (a) Informant RECORDS- BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 28-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Brooklyn, Md.

18 (a) Funeral director Elroy J. Wilson
(b) Address 1000 Beanty ave

19 (a) 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23 (month) (day) 48 (year) at 11:25 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8-16 '48 to 9-23 '48, and that I last saw him alive on 9-23 '48

Immediate cause of death For advanced bilateral pulmonary tuberculosis

Due to Tuberculous abscesses prostate & testicle

Duration 2 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M D
Address Baltimore City Hosp. Date signed 9-25-48

VS 150

657131

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 ✓ Registered No. 657131

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1834 N.Castle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 N.Castle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel C.Blizzard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Nellie E.Parlett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14,1870

8. AGE: Years	Months	Days	If less than one day: hr.	min.
77	10	11		

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Samuel C.
13. Birthplace N.J.

MOTHER
14. Maiden Name Rebecca Gandy
15. Birthplace N.J.

16 (a) Informant Nellie E.Blizzard
(b) Address 1834 N.Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/ 28/48 (month) (day) (year)
(c) Cemetery or crematory Mt.Olivet
Location Frederick Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 Broadway.

19 (a) SEP 27 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1948, at 8 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1948 to Sept 25 1948.
and that I last saw h/ alive on Sept 25, 1948.

Immediate cause of death
Arteriosclerotic Cardiovascular disease

Due to

Due to

Other Conditions Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 7 | 2 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Eugene S. Blum
Address 1115 N. Calvert St. Date signed 9/25/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 to a

Registered No. 671332

671332

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Gaton & Wilkens

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1943 Annapolis ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mrs Anne Baer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. V

6 (b) Name of husband or wife Adam R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-7-1906

8. AGE: Years 42 Months 4 Days 19 If less than one day hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Charles Etter

13. Birthplace Penna

MOTHER 14. Maiden Name Melinda Summers

15. Birthplace Penna.

16 (a) Informant Mr ADAM R BAER

(b) Address 1943 ANNAPOLIS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 30'48 (month) (day) (year)

(c) Cemetery or crematory GRINDSTONE HILL

Location CHAMBERSBURG - PA

18 (a) Funeral director Harry A Wiseley

(b) Address 4101 Edmondson ave

19 SEP 27 1948 (Date rec'd by registrar) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1948; at 7:12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17/48 to 9/26/48 and that I last saw h[illegible] alive on 9/26/48 7:

Immediate cause of death UREMIA → Duration 9 days

Due to Hydronephrosis

Due to Carcinoma of cervix with extension to pelvic organs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma of cervix

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. **Signature** Rafael D. Ramirez M. D.

Address Date signed

Rafael D Ramirez

VS 150

6671133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 6671133

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 N Pulaski St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) **FULL NAME** MRS EMMA V. LANG

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late Henry C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 25, 1948

8. AGE: Years 68 | Months 11 | Days 2 | If less than one day: hr. min. 99

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Ridgeway
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Pettee
15. Birthplace Md.

16 (a) Informant Mrs Else Smallwood
(b) Address 504 N Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 28 '48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Ave

18 (a) Funeral director Harry A Witzke Jr.
(b) Address 4101 Edmondson Ave

19 (a) SEP 27 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Sept. 1948 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Sept. 1948 to 25 Sept. 1948 and that I last saw her alive on 25 Sept. 1948

Immediate cause of death: Generalized Carcinomatosis — Duration: about

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Joseph R Liberto
Address Bon Secours Hosp. Date signed 25 Sept 48

VS 150

3671 34

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 3671 34

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County None
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Knights of Columbus Club (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Mitchell
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 24, 1877

8. AGE: Years	Months	Days	If less than one day hr.	min.
71	7	2		

9. Birthplace Mass. (Town, county, and state)
10. Usual Occupation Monument Business
11. Industry or business

FATHER
12. Name Arthur L. Mitchell
13. Birthplace Mass

MOTHER
14. Maiden Name Lucy Angeli
15. Birthplace

16 (a) Informant Miss Katherine Lederer
(b) Address 2903 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery ~~Cremetary~~ Loudon Park
Location 3801 Frederick Ave., Baltimore

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1800 Eutaw Place

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1948 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1948 to 9/26 1948 and that I last saw h. alive on 9/26 1948

Immediate cause of death Coronary Thrombosis ?

Duration

Due to Coronary Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Farano M.D.
Address Md. Gen. Hosp. Date signed 9/26/48

VS 150

67335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 549

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4804 Edgar Terrace
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [illegible]
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4804 Edgar Terrace (If rural give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Alexander G. Fedak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Dorothy Gayle Piper
6 (c) If alive, give age 30 years

7. Birth date of deceased mo., day, yr January 1, 1912

8. AGE: Years	Months	Days	If less than one day
36	8	24	hr. min

9. Birthplace New York City (Town, county, and state)
10. Usual Occupation Chemical Engineer
11. Industry or business Mutual Chemical Corp, 13 yr

FATHER
12. Name Gregory Fedak
13. Birthplace Austria

MOTHER
14. Maiden Name Eva Dran
15. Birthplace Austria

16 (a) Informant Mrs. Dorothy Gayle Fedak
(b) Address 4804 Edgar Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/40 (month) (day) (year)
(c) Cemetery ~~Secretary~~ Mount Hope, Location New York City

18 (a) Funeral director John C. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) SEP 27 1940 (b) [illegible] Huntington Woods Maryland
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1940, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 22, 1940 to Sept 25, 1940 and that I last saw him alive on Sept 25 1940

Immediate cause of death Rheumatic endocarditis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 54 S. Fulton Ave. Date signed

667136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667136 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N Calhoun
(c) Hospital or institution: Franklin Sq. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 N. Bentalou (If rural give location)
(e) Citizen of foreign country? Yes or (No)
If yes, name country

3 (a) FULL NAME Edwin H. Johnston

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-01-0616

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Bessie M. Johnston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): May 5, 1892

8. AGE: Years: 56 Months: 4 Days: 19 If less than one day: hr. min.

9. Birthplace: Philadelphia, Pa (Town, county, and state)

10. Usual Occupation: Asst manager.

11. Industry or business: F. S. Royster Guano Co.

FATHER 12. Name: Harry Johnston
13. Birthplace: Ireland

MOTHER 14. Maiden Name: Mary Sigafoos
15. Birthplace: Bucks Co., Pa

16 (a) Informant: Bessie Johnston
(b) Address: 1217 N Bentalou, Balt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1948 at 2:30 PM

21. I certify that I attended deceased from 9-23 1948 to 9-24 1948, and that I last saw him alive on 9-24 1948

Immediate cause of death: Heart failure (Coronary embolism)
Due to: Emphysema
Due to: Chronic tuberculosis
Other Conditions: Papilloma of bladder.
(Include pregnancy within 3 months of death)

Duration: 6 mo.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq. Hosp. Date signed 9-24-48

VS 150

Fold here. Give the causes of death clearly and legibly.

67137

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 67137

Registered No. 82a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1503 Lakeside Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Lakeside Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME JOHN H. FERGUSON

3 (b) If veteran, name war: no

3 (c) Social Security Account No.:

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Clara Ferguson

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 18, 1879

8. AGE: Years: 69 | Months: 8 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: President

11. Industry or business: Monumental Printing Co.

FATHER
12. Name: John H. Ferguson
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Ida Rathell
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. John H. Ferguson
(b) Address: 7 E. Gittings Ave.

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof: 9/28/48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1948, at 5:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 1-1- 1948 to 9-25 1948 and that I last saw h[illegible] alive on 9-25-1948.

Immediate cause of death

Due to Cerebral hemorrhage

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

1/2 hour

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Edward H. Adams M.D.

Address 7 W. Fayette Date signed 9-27-48

VS 150

G67138

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

✓ G67138 Registered No. ....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4208 Berger Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4208 Berger Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME LILLIAN MAY BOWEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife German W. Bowen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1893

8. AGE: Years	Months	Days	If less than one day
55	7	25	hr. 4 min.

9. Birthplace Howard Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Eli Sheppard
13. Birthplace Howard Co., Md.

MOTHER
14. Maiden Name Annie Ray
15. Birthplace Howard Co., Md.

16 (a) Informant Mr. German W. Bowen
(b) Address 4208 Berger Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory Mountain View Cem.
Location Alpha, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Certificate filed

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1948, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1948, to Sept 25 1948, and that I last saw her alive on Sept 25 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	4d
Due to Nephritis - 4 years and Metastases	
Due to	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Ed Stevens M. D.
Address 2878 Liberty Rd Date signed 9-27-48

VS 150

67189

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. [illegible]

Important. Physicians: please write the causes of death clearly and legibly. This section should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1105 Poplar Grove St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 N. Longwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGIE E. FOARD

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband ~~xxxxx~~ Charles H. C. Foard
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Dec. 17, 1864

8. AGE: Years	Months	Days	If less than one day
83	9	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Edwin Chance
13. Birthplace Unknown

MOTHER
14. Maiden Name Annie Barnshaw
15. Birthplace Martinsburg W. Va.

16 (a) Informant Mrs. Edna L. Rupfield
(b) Address 32 E. 25th St. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/45 (month) (day) (year)
(c) Cemetery or crematory ~~xxxxxxxxx~~ Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director W. J. TICKNER & SONS INC.
(b) Address North & Fa. Aves. Balto. Md.

19 (a) SEP 27 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1945, at 12 M

21. I certify that death occurred on the date above stated, that I attended deceased from 1923 to 9-24-1945, and that I last saw [illegible] alive on 9-24-1945.

Immediate cause of death: Cerebral Hemorrhage
Due to: Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration: 1 day, 5 hrs.

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address [illegible] Date signed 9-27-45

VS 150

66714O

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12 12

Registered No. 66714O

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 141 N. Monastery Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 141 N. Monastery Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME JOHN A. HAYNIE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	217-01-9153

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Rosa Etta Haynie (nee Walker) 6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Dec. 3, 1874

8. AGE: Years	Months	Days	If less than one day
73	9	23	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Edwin L. Haynie
13 Birthplace Va.

MOTHER
14. Maiden Name Margaret Berry
15 Birthplace Va.

16 (a) Informant Mrs. Rosa E. Haynie
(b) Address 141 N. Monastery Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem. Pk.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1948, at 4:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1948 to Sept. 26 1948. and that I last saw him alive on Sept. 26 1948

Immediate cause of death Pulmonary Tuberculosis — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify two of these)
(e) Means of injury

23. Signature J. H. Mason M.D.
Address 617 N. York St. Date signed 9/27/48

VS 150

Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

67141 ✓ Registered No. 67141

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Provident Hospital

(c) Hospital or institution: 1514 - Division St.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1103 - W. Lanvale (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Kate Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Negro

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Charles Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 1888

8. AGE: Years 60 Months 6 Days 7 If less than one day hr. min.

9. Birthplace Charles Co. Md. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Sayer

13. Birthplace Charles Co. Md.

MOTHER 14. Maiden Name Anne Sayers

15. Birthplace Charles Co. Md.

16 (a) Informant Louise Robinson

(b) Address 2712 Bookert Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 28, 1948 (month) (day) (year)

(c) Cemetery or crematory Western Star Cem.

Location

18 (a) Funeral director Mrs Katie A Williams

(b) Address 322 N Schroeder St

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24- 48 at 10:40 P M

21. I certify that death occurred on the date stated, that I attended deceased from 9-24 48 to 9-24 48

and that I last saw h[illegible] alive on 9-24 48

Immediate cause of death Cerebral vascular accident — Duration

Due to M. Hypertension

Due to

Other Conditions

CERTIFICATION APPROVED BY

Thomas S. Mercer, M.D.

per S.M. Davis

CHIEF OR ASST. MEDICAL EXAMINER

M. D.

(Include Pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature S. [illegible] Brady M.D.

Address Provident Hosp Date signed 9-27-48

VS 150

667142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 667142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2856 Harford Road
(c) Hospital or institution: 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2856 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Franklin Leroy Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary A. Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 1st, 1884

8. AGE: Years	Months	Days	If less than one day
64	5	24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Poultry Business (Ret.)
11. Industry or business

FATHER
12. Name Wm. L. Wilson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Annabelle Preston
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mary B. Wilson
(b) Address 2856 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director E. I. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 SEP 27 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1948 to Sept 25 1948, and that I last saw him alive on Sept 24 1948.

Immediate cause of death	Duration
Asphyxia Cardiac Insufficiency	2 mo.
Due to Arteriosclerosis	20 yrs.
Due to Cerebral Hemorrhage Apoplexy	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred. I. Fanning M.D.
Address 2858 Harford Rd Date signed 9/27/48

VS 150

667143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 667143

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) ~~Hospital~~ or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL ~~RESIDENCE~~ OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 Willow
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marian W. Harbaugh

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-20-3482

4. Sex	5. Color or race	6 (a) Single, ~~married~~ widowed, or divorced
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 24 1926

8. AGE: Years	Months	Days	If less than one day
21	10	3	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Typist
11. Industry or business

FATHER
12. Name EZRA W HARBAUGH
13. Birthplace WESTMINSTER, MD.

MOTHER
14. Maiden Name MARY C NEWMAN
15. Birthplace WESTMINSTER MD

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 30 1948 (month) (day) (year)
(c) Cemetery ~~or crematory~~ RIDERS CEMETERY
Location NEAR WESTMINSTER MD

18 (a) Funeral director JOHN R. BYERS
(b) Address WESTMINSTER, MD.

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Funeral Director for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1948 at 12 55 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/25 1948 to 9/27 1948
and that I last saw h~~e~~r alive on 9/27 1948

Immediate cause of death: Respiratory Failure — Duration

Due to Acute Edema.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C Blanche Maryland General Hospital M.D.
Address

VS 150

667144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

667144 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 339 Calvert
(c) Hospital or institution Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3927 Canterbury Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Chambers Van Lear

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Jno. Findlay Van Lear
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 21 1872
8. AGE: Years 76 | Months 4 | Days 5 | If less than one day: hr. min.
9. Birthplace Chambersburg Pa. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Geo. B. Chambers
13. Birthplace Chambersburg Pa.

MOTHER
14. Maiden Name, Emily Bright
15. Birthplace Pottstown, Pa.

16 (a) Informant Emily F. Van Lear daughter
(b) Address 3927 Canterbury Rd. 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-48 (month) (day) (year)
(c) Cemetery or crematory River View
Location Williamsport - Md

18 (a) Funeral director STEWART & MOWEN COMPANY (W. F. STEWART SUC.)
(b) Address 100 W. NORTH AVENUE

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Funeral Director Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1948 at 12 N M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/26 1948 to 9/26 1948 and that I last saw h[er] alive on 9/26 1948

Immediate cause of death: Cerebrovascular accident — Duration: 8 hrs ?
Due to: Arteriosclerosis
Due to:
Other Conditions: Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature H. Wellham M.D.
Address Hagerstown Md. Date signed 9/26/48

VS 150

G67145

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 16 1a

Registered No. G67145

Please write the causes of death clearly and legibly. The ... must be carefully supplied. The ... imperative. Physicians:

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Mt. Airy (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Baby maloney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/20/48

8. AGE: Years	Months	Days	If less than one day
			3 hr. 48 min.

9. Birthplace University Hosp - Balto - Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name William Paul Maloney
13. Birthplace Dayton Md.

MOTHER
14. Maiden Name Edna Irene Burth
15. Birthplace Woodbine, Md

16 (a) Informant Irene B. Maloney
(b) Address Mt. Airy, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory [redacted] SEP 24 1948
Location

18 (a) Funeral director [redacted]
(b) Address

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) [redacted] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1948, at 1:01 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20 1948 to 9-21 1948, and that I last saw h[illegible]m alive on 9-21 1948.

Immediate cause of death Respiratory Failure — Duration

Due to Intraventricular Hemorrhage?

Due to Erythroblastosis Fetalis

Other Conditions Hepatosplenomegaly
Splenic regular, Clinical ... dic
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. A. Peterson M. D.
Address University Hosp Date signed 9-21-48

VS 150

657146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 657146

160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Franklin & Calhoun
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 43 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore ~~Baltimore~~ Essex
(c) City or town ~~Baltimore~~
(If outside city or town limits, write RURAL and give town)
(d) Street No. 527 Dorsey ave
(If rural route location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Peggy Ann Weidinger

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 9-19-48

8. AGE: Years | Months | Days 1 | If less than one day 14 hr. 13 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name John George Weidinger
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Merriken
15. Birthplace Baltimore Md.

16 (a) Informant Margaret Weidinger
(b) Address 527 Dorsey Ave - Essex, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School SEP 24 1948
Location

18 (a) Funeral director Chas. Gardner Dept. of Health
(b) Address

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1948, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1948, to 9/21 1948, and that I last saw her alive on 9-21 1948.

Immediate cause of death Respiratory failure

Due to Atelectasis

Due to Intracranial hemorrhage.

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Wm. Christopher Jr. M.D.
Address Franklin Sq. Hosp. Date signed 9/21/48

VS 150

147

BC-48-20493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. 667147

1. PLACE OF DEATH:

(a) Baltimore City Maryland

(b) Street address Fayette & Calvert Sts.

(c) Hospital or institution: Franklin Square Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 38hr.

(e) Length of stay in Baltimore (yrs., mos., or days) 38hr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 629 N. Calvert St. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Grimes

3 (b) If veteran, name war —

3 (c) Social Security Account No —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-22-48

8. AGE: Years | Months | Days | If less than one day 1 hr. 38 min. 20

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Samuel Grimes

13. Birthplace Clarksville Md.

MOTHER 14. Maiden Name Doris Beel

15. Birthplace Baltimore, Md.

16 (a) Informant Doris Grimes

(b) Address 629 N. Calvert St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School

Location SEP 27 1948

18 (a) Funeral director City Commissioner of Health

(b) Address

19 (a) SEP 27 1948 (Date rec'd by registrar) (b) Evergreen Cemetery Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23 1948 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1948 to 9-23 1948 and that I last saw him alive on 9-23 1948

Immediate cause of death: Respiratory failure — Duration

Due to: Atelectasis

Due to: Cerebral Hemorrhage

Other Conditions: Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. M. Churchill Jr. M.D.

Address Franklin Sq. Hospital Date signed 9/23/48

VS 150

G67148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G67148

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1321 Clipper Heights Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1321 Clipper Heights Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Jane Lee

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 8, 1868

8. AGE: Years 80 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Malachi Lee
13. Birthplace North Carolina

MOTHER
14. Maiden Name Alice Hardy
15. Birthplace North Carolina

16 (a) Informant John Edward Lee
(b) Address 3921 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Mary's (Hampden)
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) SEP 27 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH September 26, 1948 at 5.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 Sept 26 1948. and that I last saw her alive on Sept 26 1948

Immediate cause of death
(a) Arteriosclerotic (CVD
(b) Decomp.

Duration 7

Due to

Due to

Other Conditions Possible Ca. Rectum

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Kinnamon M. D.
Address 571 Dall Pl Date signed 9-27-48

VS 159

G67149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 925

G67149 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 737 Bartlett Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

2. USUAL RESIDENCE OF DECEASED;
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 737 Bartlett Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Pauline Elinor Hockenberry

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elmer W. Hockenberry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 19, 1904

8. AGE: Years 44 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Steelton, Pennsylvania (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Albert Morrett
13. Birthplace Vermont

MOTHER 14. Maiden Name Margaret Beauplon
15. Birthplace Vermont

16 (a) Informant Elmer W. Hockenberry
(b) Address 737 Bartlett Avenue

17 (a) Removal & Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Churchtown
Location near Carlisle, Pennsylvania

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) SEP 27 1948 (Date rec'd by registrar) Curtis Bay Williamsport, Md.

MEDICAL CERTIFICATION A.

20. DATE OF DEATH September 26, 1948, at 8.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Aug 1948, to 26 Sep 1948.
and that I last saw h[illegible] alive on 24 Sep 1948

Immediate cause of death Coronary occlusion — Duration Immed

Due to Hypertensive heart disease — Duration 5 years +

Due to

Other Conditions Post coronary occlusion on 5 Aug 48
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M D
Address 2020 N. Charles St Date signed 27 Sep 48

VS 150

667150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 East Lorraine Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 E. Lorraine Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN AMBROSE HUNT

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Pearl Suter Hunt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1885

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chauffer, Diamond Cab.
11. Industry or business

FATHER
12. Name Thomas Hunt
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Kelly
15 Birthplace Md.

16 (a) Informant Mrs. Pearl Hunt
(b) Address 301 E. Lorraine Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location City

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) SEP 27 1948 (Date rec'd by registrar) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25/48 19 . at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 45 to Sept 25 19 48, and that I last saw h[illegible] alive on Sept 23 19 48.

Immediate cause of death Cerebral thrombosis — Duration 2 min
Due to arteriosclerosis — 1 year
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Egbert K. Mortimer Jr
Address 2706 St Paul Date signed 9/27/48 M D

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67151 | Registered No. G67151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 East Clement Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 East Clement Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Ernest Ray Ritter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Martha A. (La Barre)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) II/28/1904

8. AGE: Years 43 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Hagerstown, Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Sierra Lumber Company

FATHER
12. Name William H. Ritter
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary G. Shimp
15. Birthplace Virginia

16 (a) Informant Family
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Avenue

18 (a) Funeral director James L. McCauley
(b) Address 130 East Fort Avenue

SEP 27 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1948 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1946 to Sept 24 1948 and that I last saw him alive on 24 1948.

Immediate cause of death: Cerebral Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Ritter M. D.

Address 203 Talafierro Date signed 9/27/48

X

G67152 BC- 48-20676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157M

Registered No. G67152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County WORCESTER
(c) City or town SNOW HILL (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 FEDERAL ST (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BABY "ALBERTA" HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-25-48

8. AGE: Years	Months	Days	If less than one day
—	—	2	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business

FATHER
12. Name EDWARD HARRIS
13. Birthplace Md.

MOTHER
14. Maiden Name ALBERTA WILLIAM
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof SEP 28 1948 (month) (day) (year)
(c) Cemetery or crematory Woodcock
Location Snow Hill, Md.

18 (a) Funeral director Lilley & Barnes
(b) Address Snow Hill, Md.

19 (a) SEP 28 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1948, at 9:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1948 to 9-27 1948, and that I last saw her alive on 9-27 1948.

Immediate cause of death Prematurity — Duration

Due to Tumor of Heart?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Autopsy Tumor of Heart (type undetermined)

of autopsy: ↗

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Eugene I. Goldstein M. D.
Address Johns Hopkins Hospital Date signed 9/27

VS 159

67153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67153

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster Md Route 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME A. Marshall MASON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Charlotte S. Mason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1919

8. AGE: Years 28 29 | Months 10 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business

FATHER
12. Name John A. Mason
13. Birthplace Md.

MOTHER
14. Maiden Name Florence A. Spath
15. Birthplace Md.

16 (a) Informant Mrs. J. A. Mason
(b) Address Route #7 Westminster, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-1948 (month) (day) (year)
(c) Cemetery or crematory Meadow Branch Cemetery
Location Westminster, Md.

18 (a) Funeral director C. O. Fuss & Sons
(b) Address Taneytown, Md.

19 SEP 28 1948 (Date rec'd by Local Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Sept 1948, at 6 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Sept 1948, to 27 Sept 1948, and that I last saw him alive on 27 Sept 1948.

Immediate cause of death: Cardio-resp. failure — Duration

Due to: renal sclerosis, arteria

Due to: pulmonary tbc - active miliary tbc -

Other Conditions: G.U. tbc advanced

(Include pregnancy within 3 months of death)

Date of operation (1942)

Major findings of operation: Tb Kidney

of autopsy: advanced miliary tbc

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving Sokale M.D.
Address Sinai Hospital Date signed 28 Sept 48

VS 150

667154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

667154
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2027 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanora Beck Hunt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ Howard S. Hunt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9th 1879

8. AGE: Years	Months	Days	If less than one day
68	10	18	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm H. Beck
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Snyder
15. Birthplace Balto. Md.

16 (a) Informant Howard S. Hunt
(b) Address 2027 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (c) SEP 28 1948 Huntington Williams Mgr
(Date rec'd by registrar) (Local Registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27th 1948, at 4 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1948 to Sept 27 1948, and that I last saw her alive on Sept 26 1948.

Immediate cause of death Cerebral accident. Coronary thrombosis (arterial)
Due to Chronic Hypertension (arterial)
Due to uterus & ovaries —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

Duration 1 yr 5 mo

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which) (Name)
(e) Means of injury —

23. Signature John F Hemmeter M.D.
Address 722 N Howard St Date signed Sept 27/48

G67155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67155

GN. 87932

107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
B ltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 Harford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eunice Ely

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 Nov. 13

8. AGE: Years	Months	Days	If less than one day
66	10	25	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Enosh Ely
13. Birthplace Conn.

MOTHER
14. Maiden Name Victoria Walters
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director H. C. Cain Son Inc.
(b) Address 1223 E. Paul St.

19 (a) SEP 28 1948 (Date rec'd by registrar) (Huntington Williams) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 26 - 1948 at 6.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5- 10 - 1944 to 9- 26- 1948 and that I last saw h er alive on 9-26- 1948

Immediate cause of death: aspiration pneumonia. — Duration: 2 days

Due to: Arteriosclerosis generalized.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Vinlen Jr. M.D.
Address Balto City Hosp Date signed 9-28-48

VS 150

67156 NEENAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

Registered No. 67156

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Hudson st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Neenan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ Thomas A. Neenan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15th 1907

8. AGE: Years 40 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John S. Burk
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Nora E. Johnson
15. Birthplace Balto. Md.

16 (a) Informant Vivian Neenan
(b) Address 2900 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. G. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) SEP 28 1948 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1948 at 6:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1948 to Sept 26 1948 and that I last saw h[illegible] alive on Sept 26 1948.

Immediate cause of death Septicemia — Duration

Due to Liver abscess

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Sept 1, 1948

Major findings of operation: Chronic [illegible] Liver abscess

of autopsy: Liver abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan H Mould M.D.
Address Broadway Date signed Sept 28 1948

VS 150

G67157

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92

G67157 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Fauvens Pl
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Fauvens Pl (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Elsie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Unknown

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Agnes Rolls

(b) Address 46 N 27 S W Washington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28/48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Brooklyn

18 (a) Funeral director J. Brooks

(b) Address 1463 N Carey St

19 SEP 28 1948 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1948, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1947 to Sept 26 1948 and that I last saw her alive on Sept 24 1948.

Immediate cause of death Cardio Vascular Disease — Duration 1 yr

Due to Broken Compensation — Duration 6 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature E William Frey M.D.

Address 1928 Penna Ave Date signed Sept 27/48

VS 150

6[illegible]158 4

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92a

Registered No. 667158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 809 S. Sharp St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALEXANDER GRIER, JR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: Mozella —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 45 | Months | Days | If less than one day: hr. min.

9. Birthplace Cleveland, N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Alex. Grier
13. Birthplace N.C.

MOTHER
14. Maiden Name Laura —
15. Birthplace

16 (a) Informant Mozella Grier
(b) Address 809 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A. Adams
(b) Address 142 N. Broadway

SEP 28 1948 (Date rec'd by registrar) Carrington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21, 1948, at 6:00 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Aortic Stenosis
Hypertrophy of Heart
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Ryder M.D.
Medical Examiner
Date signed 21 Sept 48

VS 551

67159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

67159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 W. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN C. SPEARS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1876

8. AGE: Years 71 | Months 64 | Days 10 | If less than one day hr. min. 13

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name ?

13. Birthplace Virginia

MOTHER 14. Maiden Name ?

15. Birthplace Virginia

16 (a) Informant Ross Nowlin

(b) Address 229 Bishop Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29, 1948

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director A. Halsteadt

(b) Address 918 Druid Hill Ave.

19 SEP 28 1948 (Date rec'd by registrar) Huntington Williams, Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1948, at 12.15 a M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A. S. C. V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Medical Examiner M.D.

Date signed September 25, 1948

VS 151

CERTIFICATE CORRECTED 11-8-49 ✓ 667160

667160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution:
Stoney Run Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1wk.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Charles
(c) City or town La Plata
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Vernon Padgett

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife Pearl Isola

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23-1881

8. AGE: Years	Months	Days	If less than one day: hr.	min.
67	1	4		

9. Birthplace La Plata Md
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name [illegible] Padgett
13. Birthplace Johns Co Md

MOTHER 14. Maiden Name [illegible] Roberta Tucker
15. Birthplace

16 (a) Informant Francis Padgett
(b) Address Waldorf Md

17 (a) Burial (b) Date thereof 9-30-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Rest
Location La Plata Md

18 (a) Funeral director Hurst & Ryan
(b) Address Waldorf Md

19 (a) SEP 28 1948 (b) Huntington Williams 42
(Date received by local registrar) (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1948, at 1.20 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from July 1948 to Sept 27 1948, and that I last saw h[illegible] alive on Sept 27 1948

Immediate cause of death Cardio-Myopathy Failure — Duration

Due to Coronary occlusion

Due to Arteriosclerotic Cardiovascular disease, Chronic myocarditis

Other Conditions

(Include pregnancy within 3 mos. of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howland E. Day M.D.
Address 4 E 33rd St
Date signed Sept 27, 1948

VS 150

667161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. 667161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave.
(c) Hospital or institution:
Ardleigh Nursing Home. 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 832 W. 34th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Roy Rodgers.

3 (b) If veteran, name war ---------

3 (c) Social Security Account No. 212-10-7262

4. Sex: Male.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Mattie I. Rodgers.

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1881

8. AGE: Years 67 | Months - | Days 3 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Machinist.

11. Industry or business Balmar Corp.

FATHER
12. Name Benjamin F. Rodgers.
13. Birthplace Md.

MOTHER
14. Maiden Name Julia A. Wilhelm.
15. Birthplace Md.

16 (a) Informant Mattie I. Rodgers.
(b) Address 832 W. 34th St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Sept, 29, 48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn, Md.
Location Woodlawn, Md.

18 (a) Funeral director Paul E. Chenoweth Jr.
(b) Address 3615-17 Chestnut Ave.

19 (a) SEP 28 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1948 at 11p M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1948 to July 26 1948, and that I last saw h[illegible] alive on July 26 48.

Immediate cause of death Bronchopneumonia — Duration 2 weeks

Due to Carcinoma of prostate — Duration diagnosed July 10/48

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 29/48

Major findings of operation: Carcinoma of prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Wellington M. D.

Address 848 W 36th Date signed 9/27/48

VS 150

67162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67162

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 N. Bentlou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 N. Bentlou St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME William Weber

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 21, 1879

8. AGE: Years 68 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Payroll Clerk

11. Industry or business Dreyer Box Company

FATHER
12. Name Henry Weber
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Elgert
15. Birthplace Germany

16 (a) Informant Miss Ruth E. Jaeger
(b) Address 1012 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director John T. Stansbury
(b) Address 2700 Edmondson Ave.

19 (a) SEP 28 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1948 at 1145 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Sept 26 1948.
and that I last saw him alive on Sept. 26 1948.

Immediate cause of death: Coronary Thrombosis — Duration: 1/2 hour
Due to: Arterio sclerotic type heart disease with Adipose — Duration: 3 years
Due to: Enlargement + hypertension
Other Conditions: Angina pectoris
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Michel M. D.
Address 2901 Edmondson Ave Date signed Sept 27 1948

67163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

G67163

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: MARYLAND GENERAL HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 McELDERRY ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) **FULL NAME** ANDREW James NEUBERGER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of ~~husband~~ or wife Margaret Ulrich

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) FEB 2, 1879

8. AGE: Years	Months	Days	If less than one day
69	7	24	hr. ____ min.

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business —

FATHER
12. Name THOMAS NEUBERGER
13. Birthplace BALTO. MD

MOTHER
14. Maiden Name CATHERINE LEIMKUHLER
15. Birthplace BALTO, MD

16 (a) Informant EDWARD NEUBERGER
(b) Address SAME AS DECEASED

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/48 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Moreland Memorial Park
Location 5806 Harford Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison St., Balto. Md.

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Huntington W. Wiegand M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 SEPT 1948 at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 20 AUG 1948 to 26 SEPT 1948. and that I last saw HIM alive on 26 SEPT 1948.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	2 HOURS
Due to CHRONIC FIBRO-CASEOUS PULMONARY TUBERCULOSIS WITH CAVITATION, RIGHT LUNG	ABOUT 7 YEARS.
Due to	
Other Conditions MARKED CACHEXIA	6 MOS.

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of ~~operation~~ AUTOPSY • DENSE PLEURAL ADHESIONS WITH A LARGE PUS FILLED CAVITY IN RIGHT UPPER LUNG

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Donald F. England
Address Maryland Gen. Hosp. Date signed 26 Sept 48

VS 150

X

67164 H269-0

G67164

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 83a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2116 W. Mulberry St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Adolph Ludwig

(a) Residence: No. Emmittsburg Md St., Ward. Frederick Co.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bertrande Hagler Ludwig

6. DATE OF BIRTH (month, day, year) March 25, 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
90	6	3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Germany

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT Bertrande Ludwig

(Address) Emmitsburg, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Emmitsburg Md Date Sept 30 1948

19. UNDERTAKER S. L. Allison

(Address) Emmitsburg Md

20. FILED SEP 28 1948 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 28, 1948

22. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1948 to Sept 28, 1948

I last saw h/ alive on Sept 27, 1948 Death is said to have occurred on the date stated above, at 5:30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	9/20/48

Other contributory causes of importance:

Arteriosclerosis

Hypertension

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) D. M. Collins M. D.

(Address) 332 Frederick St

X

G67165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

Registered No. 67165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 240 Laurnes St.
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) ***
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 240 Laurnes St.
(If rural give location)
(e) Citizen of foreign country? ******* (Yes or No)
If yes, name country ********

3 (a) FULL NAME ELEANOR ~~ELANOR~~ REED MEEHAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Thomas J. Meehan
6 (c) If alive, give age **years

7. Birth date of deceased (mo., day, yr.) Not obtainable

8. AGE: Years	Months	Days	If less than one day
About 49	***	**	** hr. ** min.

9. Birthplace New Jersey
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ****** Reed
13. Birthplace Not obtainable

MOTHER
14. Maiden Name Margaret Coyle
15. Birthplace Ireland

16 (a) Informant Mrs. James A. Travis
(b) Address 7512 Berkshire Road T 24

17 (a) Burial (b) Date thereof 9/29/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meade and Son
(b) Address 805 N. Calvert Street

19 (a) SEP 28 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1948, at 8:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fatty degeneration of liver
Esophageal varices

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Morrill M.D.
Medical Examiner
Date signed 9/27/48

VS 151

CERTIFICATE APPROVED BY Vital Statistics Section

667166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 186a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts

(c) Hospital or institution Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore 18 Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. Bishop Rd, Baltimore 18 Md.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LELIA S. ALVEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife J. Richard Mc. Alvey

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
88	11	18	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Martin Scott (D)

13. Birthplace Virginia

MOTHER

14. Maiden Name Pocahontas Bernard (D)

15. Birthplace Virginia

16 (a) Informant Martin S. Alvey

(b) Address 1 W. Bishop Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/48 (month) (day) (year)

(c) Cemetery or crematory

Location Bay Mount Va.

18 (a) Funeral director H. W. Mears and Son

(b) Address 505 N. Calvert St.

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1948, at 7 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1948. to Sept 26 1948, and that I last saw her alive on Sept 26 1948.

Immediate cause of death Pulmonary embolus — Duration

Due to

Due to INTERNAL HAEMORRHAGE

Other Conditions Pulmonary edema. Intertrochanteric fracture Lt. femur
(Include pregnancy within 3 months of death)

Date of operation 9/20/48

Major findings of operation: Intertrochanteric fracture left femur

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence Sept 14 at M

(c) Where did injury occur? home.
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(Specify type of place)

(e) Means of injury fell & slipped and fell to floor

23. Signature Charles N. Watt, Jr. M. D.

Address Union Memorial Hosp. Date signed 9/27/48

VS 150 To be signed by Medical Examiner

67167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12/a

Registered No. G67167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 Ausquith Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Ausquith Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Emma H. Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1875

8. AGE: Years	Months	Days	If less than one day
73	2	24	hr. min.

9. Birthplace Ellicott City Howard County Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Hebbons
13. Birthplace Lancaster County Va

MOTHER
14. Maiden Name Lizzie
15. Birthplace Ellicott City Maryland

16 (a) Informant Mrs C. Dembry
(b) Address 729 N Fremont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29 1948 (month) (day) (year)
(c) Cemetery or crematory Mount Lyon
Location Baltimore County Md

18 (a) Funeral director Joseph A Lucy
(b) Address 66 W Baltimore St

19 (a) SEP 28 1948 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1941 to Sept 24 1948.
and that I last saw him alive on Sept 22 1948.

Immediate cause of death: Coronary Thrombosis
Due to: Hypertensia
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration: 3 Months

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. O. Stewart M. D.
Address 1032 N Fremont ave Date signed Sept 27

VS 150

67168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906½ Preice St.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 906½ Preice St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannie Lipscomb.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Aaron Lipscomb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1884

8. AGE: Years 64 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Essex County, Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Randall Roane.
13. Birthplace Essex County, Va.

MOTHER
14. Maiden Name Catherine
15. Birthplace Essex County, Va.

16 (a) Informant Rebecca Nicholson
(b) Address 454 Manhattan Apts. N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Hattie A. Williams
(b) Address 322 N. Schroeder St.

19 SEP 28 1948 (Registered by Registrar) Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1948, at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1948 to Sept 28 1948 and that I last saw h alive on Sept 25 1948

Immediate cause of death
Cardiac Renal
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
2
mo

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed

VS 150

57169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 57169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 866 Vine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 866 Vine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Luther Stephens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Co	Widower

6 (b) Name of husband or wife Blanche Stephens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) November 17, 1893.

8. AGE: Years	Months	Days	If less than one day
54	10	7	hr. min.

9. Birthplace Appomattox Co., Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Paul Stephens.
13. Birthplace Appomattox Co. Va.

MOTHER
14. Maiden Name Katie Isabelle
15. Birthplace Appomattox Co. Va.

16 (a) Informant Mrs. Katie Stephens.
(b) Address 866 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Wilkinson
Address 322 N. Schroeder St. Huntington Williams, W. Va.

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26 1948, at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1948 to 9/26 1948.
and that I last saw h alive on 9/26 1948

Immediate cause of death Coma Diabeticum

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. Wilkerson M. D.
Address 2479 Date signed

VS 150

67170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12a

Registered No. 67170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9 E Henrietta St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 E. Henrietta
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jamar M. Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-20-1539

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 10/11/1924

8. AGE: Years 23 | Months 11 | Days 18 | If less than one day hr 14 min

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Mayer Dept Store

FATHER 12. Name Clarence Morgan

13. Birthplace Md

MOTHER 14. Maiden Name Nancy J Martin

15. Birthplace Pa

16 (a) Informant Mr Clarence Morgan

(b) Address 9 E Henrietta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Ritchie Highway

18 (a) Funeral director J. J. Lynch & Sons

(b) Address 318 Light St

19 (c) SEP 28 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Sept. 19 48, at 8 30 M

21. I certify that death occurred on the date above stated, that I attended deceased from 24 Sept 48 to 26 Sept 48. and that I last saw h[illegible] alive on 25 Sept 48.

Immediate cause of death: Chronic nephritis
Malignant Hypertension

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E B Ellison M. D.

Address 107 E. Madison Date signed 27 Sept 48

VS 15)

67:171 BC-KP-1966 ✓ 67:171

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Child born en U.M.H.T
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3152 Keswick Road
(If rural give location)
Was never discharged
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Slater

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Infant.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/13/48

8. AGE: Years	Months	Days	If less than one day
		15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation - infant

11. Industry or business

FATHER
12. Name Harry Slater
13. Birthplace

MOTHER
14. Maiden Name Geraldine Slater
15 Birthplace

16 (a) Informant Geraldine Slater
(b) Address 3152 Keswick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Lot 11, Block 6

18 (a) Funeral director C. Howard Evans
(b) Address 1400 St. Paul St.

19 (a) SEP 28 1948 (Date received by registrar) (b) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1948, to 9/27 1948, and that I last saw him alive on 9/27 1948.

Immediate cause of death	Duration
Cardio respiratory failure	2 days
Due to Atelectasis	15 days
Due to Prematurity	15 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation -
Major findings of operation:
of autopsy: Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Catherine F. Young M. D.
Address Union Memorial Hospital Date signed 9/27/48

VS 159

CERTIFICATION APPROVED BY
Asst. Registrar for Commissioner of Health
John R. Travis M.D.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667172

1. PLACE OF DEATH. MEDICAL EXAMINER.
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution. Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 mins
(e) Length of stay in Baltimore (yrs., mos., or days) almost 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write R.F.D. and give town)
(d) Street No. 618 Collett St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley Kelley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Alice Kelley
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 1908
8. AGE: Years 39 40 | Months 11 | Days | If less than one day hr. min.
9. Birthplace Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Kelley
13. Birthplace Va

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant James Allen
(b) Address 618 Collett St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-48 (month) (day) (year)
(c) Cemetery or crematory Wakefield Va
Location Va
18 (a) Funeral director George B. Nelson
(b) Address 1303 Pennsylvania Ave
19 (a) SEP 24 1948 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1948 at 7 00 PM
21. I certify that death occurred on the date above stated, that I attended deceased from 9/24 1948 to 9/24 1948, and that I last saw him alive on 9/24 1948.
Immediate cause of death Pulmonary Edema
Due to Acute heart Failure
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature C. Brantley Lee M.D.
Address Standard Drug Co. Date signed 9-27-48

VS 150

G67173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1949

G67173

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1066 Fremont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1566 Fremont Ave
(If rural give location)
(e) If foreign born, how long in U. S. A? years

3 (a) FULL NAME Charles C. McElderry

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/24

8. AGE: Years	Months	Days	If less than one day
76	1	3	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name unk
13. Birthplace

MOTHER
14. Maiden Name unk
15. Birthplace

16 (a) Informant B. E. Smith
(b) Address 2238 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Mrs. B. Kelson

18 (a) Funeral director Chas. J. Kreutzman
(b) Address 1303 Pennsylvania Ave

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1948 at 6 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 6/29 1948 to 9/27 1948, and that I last saw h~~im~~ alive on 9/26 1948.

Immediate cause of death
Chr. Myocarditis
& Decompensation —
Due to

Due to

Other Conditions Arteriosclerosis + Hypertension.
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration (Days +)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jas J Julian M.D.
Address 711 N Eutaw St Date signed 9/28/48

VS 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 667174

667174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 Jefferson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Jefferson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lue Rine Johnson
LUERINE JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	colored	married

6 (b) Name of husband or wife Robert Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1909

8. AGE: Years	Months	Days	If less than one day
39	4		hr. min.

9. Birthplace Blair Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Stones
13. Birthplace Blair, Va

MOTHER
14. Maiden Name Sallie Thompson
15. Birthplace Blair Va

16 (a) Informant Robert Johnson
(b) Address 1629 Jefferson St

17 (a) Burial (Burial, cremation, removal) (b) Date thereof Sept. 30 1948
(c) Cemetery or crematory Thompson Cemetery
Location Blair Va

18 (a) Funeral director Robert E Williams
(b) Address 1545 McElderry

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1948, at 2.48 a.M.

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertension C. V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. Medical Examiner
Date signed September 27, 1948

VS 151

667175

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667175 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2226 Wilkens Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Estelle Gill

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife James W. Gill
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) April 17, 1880

8. AGE: Years	Months	Days	If less than one day
68	5	7 10	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Andrew Paul
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Margaret Briarton
15. Birthplace Baltimore, Md.

16 (a) Informant James W. Gill
(b) Address 2226 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-48. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick J. Cole
(b) Address 1200 W. Lombard St.

19 (a) Received by (Registrar) 9-28-1948 (b) Interment or Removal Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1948, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Sept 27 1948.
and that I last saw h[illegible] alive on Sept 26 1948.

Immediate cause of death: Cerebrovascular hemorrhage — Duration: 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 57 S. Fulton Ave. Date signed 9-27-48.

VS 153

G67176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462

Registered No. G67176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
M	C	Separated

6 (b) Name of husband or wife

6 (c) If single, the age of years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
52	49		hr. min.

9. Birthplace S. C. (Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Ben Williams

FATHER 13. Birthplace S. C.

MOTHER 14. Maiden Name Ann ?

MOTHER 15. Birthplace S. C.

16 (a) Informant Leroy Williams

(b) Address 659-S. 11th St. Richmond Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep 28 1948

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1948, at 7:45 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute congestion of Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Emil H Rupp M.D. (Medical Examiner)

Date signed 9/25/48

VS 151

667177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

667177 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 725 S. Rose St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 725 S. Rose St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EVA Mc SHANE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Joseph Mc Shane
6 (c) If alive, give age, years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day: hr.	min.
69				

9. Birthplace Lithuanian (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name	Not know
FATHER 13. Birthplace	Lithuanian
MOTHER 14. Maiden Name	Not know
MOTHER 15. Birthplace	Lithuania

16 (a) Informant Mrs. Helen Demsky
(b) Address 725 S. Rose St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29-48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Avenue

18 (a) Funeral director John A. Grabianckas Jr
(b) Address 423 S. Paca St

19 (a) SEP 28 1948 (Date received) (b) Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 48 at 8.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to Sept 19 48, and that I last saw h alive on Sept 24 19 48

Immediate cause of death: Carcinoma of Stomach — Duration: 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept, 1947

Major findings of operation: Inoperable Carcinoma of Stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeDoux
Address 601 S. Eleonard St. Date signed 9-29-48

VS 150

67178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 67178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 S. Ann St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Ann St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paulina Progrebsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Stasnilaw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Know

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russian (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Leo Danashuk
13. Birthplace Russian

MOTHER
14. Maiden Name Fedora
15. Birthplace Russian

16 (a) Informant Mrs. Anna Melnick
(b) Address 309 S. Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30-48 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Elkridge Md

16 (a) Funeral director John A. Grefhauckas
(b) Address 423 S. Paca St.

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1948 at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1948 to Sept 27 1948. and that I last saw h alive on Sept 25 1948.

Immediate cause of death
Marked Secondary Anemia
Due to Scirrhous Carcinoma of Mammary region
Due to upper mediastinum
Other Conditions Myocardial Degeneration
Pneumonia right lung
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration
Last month
1 yr 4 mo
2 yr
17 days

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following: n/a
(a) Accident, suicide, or homicide
(b) Date of occurrence Sept 10 '48 at 7 a M
(c) Where did injury occur? Ports (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? no (Specify type of place)
(e) Means of injury fell down steps.

23. Signature A. T. Rus

Address 24 S. Broadway Date signed Sept 28/48

VS 150

67179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 67179

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20min.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710W. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin H. OGLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife BESSIE K. OGLE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1902

8. AGE: Years 46 | Months 9 | Days - | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Boiler Maker

11. Industry or business Baltimore & Ohio R.R.

FATHER
12. Name George Ogle
13. Birthplace Maryland

MOTHER
14. Maiden Name Roseller Houck
15. Birthplace Maryland

16 (a) Informant Mrs. Roseller M. Gorsey
(b) Address 3206 Stanley Rd. Lansdowne

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 29/48 (month) (day)
(c) Cemetery or crematory LOUDON PARK CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE...17

19 (a) SEP 28 1948 (Date rec'd by registrar) Registrar for Millicent, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1948 at 11:15 M.

21. I certify that I took charge of the remains described above, held an Inspec. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Ryon M.D.
Medical Examiner.

Date signed 9/29/48

VS 191

67180

CERTIFICATE CORRECTED 9-1-56 ✓

BALTIMORE CITY HEALTH DEPARTMENT

ES-122621

CERTIFICATE OF DEATH 12B

667180

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Balto. City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. ~~672 Sarah Ann St.~~ 746 Bradley Ct.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Magowan or Helen Mc Gowan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Charles Magowan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): June 5?-25? ?

8. AGE: Years: 50 ? Months: 1 2 Days: 24 If less than one day: hr. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name: Henry Davis

13. Birthplace: Va.

MOTHER

14. Maiden Name: Anna?

15. Birthplace: Va.

16 (a) Informant: RECORDS- Balto. City Hospitals

(b) Address: 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 22 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) SEP 22 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4- 19 48 at 4:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 19 48 to 9-4 19 48.

and that I last saw her alive on 9-4 19 48.

Immediate cause of death: Miliary Tuberculosis — Duration: 6 mo.

Due to

Due to

Other Conditions: Arteriosclerotic Cardiovascular disease — Duration: 2yr.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature L. Stutzman

Address Balto City Hosp. Date signed 9-16-48 M. D.

VS 150

67181

J1- 13419

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 93 D

G67181 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Eutah Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Clarence Luther Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Alice P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1856

8. AGE: Years	Months	Days	If less than one day
91	11	25	hr. min.

9. Birthplace Wisconsin (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Luther Clark
13. Birthplace Iowa

MOTHER
14. Maiden Name Sarah Osborne
15. Birthplace N. Y.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 22 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4, 1948, at 11.40 PM

21. I certify that death occurred on the date above stated: that I attended deceased from Jan. 27, 1936, to Sept. 4 1948, and that I last saw h im alive on Sept. 4 1948.

Immediate cause of death: Bronchopneumonia — Duration: 3 days

Due to

Due to

Other Conditions Arteriosclerosis Cardio-vascular Disease (Include pregnancy within 3 months of death) — years

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Vinton, M. D.
Address Balto City Hosp Date signed Sept 28 48

VS 150

107

82 JL -- 120731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

✓ 667182 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home address (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Randolph Saunders

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 26, 1879

8. AGE: Years	Months	Days	If less than one day
68	10	2	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John R. Saunders
13. Birthplace Md.

MOTHER
14. Maiden Name Cornelia B. Cherry
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 22 1948
Commissioner of Health
18 (a) Funeral director
(b) Address
19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1948, at 4PM M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1948 to Aug. 28 1948, and that I last saw her alive on Aug. 28 1948.

Immediate cause of death CVA — Duration 8 hrs

Due to Gen. A.S. — Duration 3 yrs

Due to — Duration

Other Conditions Malignant retro-peritoneal tumor - recurrent (Include pregnancy within 3 months of death) — Duration 1 yr

Date of operation 5/14/45

Major findings of operation: retro peritoneal tumor

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Balt. City Hosp. Date signed 9/28/48

VS 153

83a

7183

JL - 64178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 667183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 Cloney St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15. 1865

8. AGE: Years	Months	Days	If less than one day
83	-	16	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry
13. Birthplace Md.

MOTHER
14. Maiden Name Hester ?
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 22 1948
Commissioner of Health
18 (a) Funeral director
(b) Address
19 (a) SEP 2[illegible] 1948 (b) Huntington, Indiana, M.E.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1948, at 10.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1948 to Aug. 31 1948. and that I last saw him alive on Aug. 31 1948.

Immediate cause of death: Bronchopneumonia, bilat
Due to: Arteriosclerosis, generalized
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 3 days

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wallace H. Hughes M.D.
Address Balto City Hosp. Date signed 8 Sept 48.

VS 150

184

ES- 100778

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82a

Registered No. 667184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME John G. Orr

3 (b) If veteran, name war

3 (c) Social Security Account No. 535-05-4944

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~Sept. 14, 1903~~ Sept. 14, 1903

8. AGE: Years	Months	Days	If less than one day: hr.	min.
44	11	24		

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Eugene Orr
13. Birthplace Md.

MOTHER: 14. Maiden Name ?
15. Birthplace Md.

15 (a) Informant RECORDS- Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 22 1948
Commissioner of Health

18 (a) Funeral director
(b) Address Huntington Williams, Md.

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28- 48 at 10:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-22 48 to 8-28 48 and that I last saw h im alive on 8-28 48

Immediate cause of death: Bronchopneumonia, bilat — Duration: 3 days
Due to Cerebral Vascular Accident
Due to Arteriosclerosis, generalized.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Kinlan, M.D.
Address Balto City Hosp Date signed 8 Sep 48

VS 159

7185 JL -122275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67185

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 McKim St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March ? ?

8. AGE: Years	Months	Days	If less than one day: hr.	min.
75 ?				

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Strong Brooks
13. Birthplace S. C.

MOTHER
14. Maiden Name Frances Moffitt
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 22 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 28 1948 (Date rec'd by registrar) (Signature of Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31, 1948 11.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1948 to Aug. 31 1948, and that I last saw him alive on Aug. 31 1948.

Immediate cause of death: PULMONARY TUBERCULOSIS ? — Duration: 2 MOS ?

Due to

Due to

Other Conditions CARDIAC FAILURE. SENILITY (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN: Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas P. Jennings M. D.
Address BALTIMORE CITY HOSP Date signed 9-8-48

VS 150

185 90 39

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. 157186

State Anatomical

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 319 Forrest St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Freeman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-8-88

8. AGE: Years 60 | Months 2 | Days / | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Laurent Jordan -
13 Birthplace

MOTHER
14. Maiden Name
15 Birthplace

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location

University Medical School SEP 21 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1948 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28 1948 to Sept. 9 1948 and that I last saw h alive on 19

Immediate cause of death: Carcinomatosis — Duration

Due to

Due to

Other Conditions Adhesions of Left Lower Lobe
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify on public conveyance)
(e) Means of injury

23. Signature Sherman Wilkinson M.D.
Address Johns Hopkins Hosp. Date signed 9/20/48

VS 150

X

G67187 C-48-1942 ✓ G67187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ of Md Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1264 Jones St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Boy Eitel
3 (b) If veteran, name war — Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-12-48

8. AGE: Years	Months	Days	If less than one day
		3 2	5 hr. 13 min.

9. Birthplace Univ. Hosp (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER	12. Name George Eitel
	13. Birthplace Balto Md.
MOTHER	14. Maiden Name Virgie E. Ghent
	15. Birthplace Balto Md.

16 (a) Informant mother - Virgie Eitel
(b) Address 1264 Jones St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 17 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 28 1948 (Date received by registrar) (b) Registrar

VS 150 For City Dis 105242

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-14 1948 at 1 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1948 to 9-14 1948 and that I last saw h/m alive on 9-13 1948

Immediate cause of death Prematurity

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature C. E. Raboen M. D.
Address Maternity Dept. Date signed 9-14-48

667188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 667188

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2305 St. Paul St.
(c) Hospital or institution: -
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or ~~town~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 St. Paul St. (If rural give location)
(e) Citizen of foreign country? - (Yes or No) If yes, name country -

3 (a) FULL NAME FLORENCE E GROVE

3 (b) If veteran, name war -
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed,~~ or divorced.
F	W	DIVORCED

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) OCT. 26, 1886

8. AGE: Years	Months	Days	If less than one day
61	11	1	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business -

FATHER
12. Name Joseph TRUMPOWER
13. Birthplace MD.

MOTHER
14. Maiden Name Mills
15. Birthplace Unknown

16 (c) Informant Miss Nelly M. Grove
(b) Address 24 W. 12th St N.Y. N.Y.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-30-48 (month) (day) (year)
(c) Cemetery or crematory Rest Haven
Location Hagerstown

18 (a) Funeral director Wm S. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) 9-28-1948 (Date received by registrar) (b) Registrar Florence Williams Mae

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1948, at M

21. I certify that death occurred on the date above stated, that I attended deceased from July 28 1948. to Sept 27 1948. and that I last saw her alive on Sept 17 1948.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Hepatitis recovering. — July 28-48

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: -

of autopsy: -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? - While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathaniel M Beck M.D.
Address 1002 E. 23rd St Date signed Sept 28 48

Form 150

G67189

148937

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

309

G67189
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 N. Eden, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Hyde.

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Absalom Hyde
6 (c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr): 2-28-73

8. AGE: Years: 75 | Months: 6 | Days: 27 | If less than one day: hr. min.

9. Birthplace: N. C. (Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business

FATHER
12. Name: William Bragg
13. Birthplace: N. C.

MOTHER
14. Maiden Name: Caroline Carson
15. Birthplace: N. C.

16 (a) Informant
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1948 at 11 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24-1948. to 9-25-1948. and that I last saw her alive on 9-25-1948.

Immediate cause of death: Cardiac failure - acute - right sided & acute pulmonary edema — Duration: 6 hrs.
Due to: Arteriosclerotic cardiovascular Disease
Due to: Generalized arteriosclerosis
Other Conditions: Pernicious anemia - Rx Cirrhosis (Banti's), Syphilis - latent Rx
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: — None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify which place)
(e) Means of injury

23. Signature: O. Jackson, M.D.
Address: The Johns Hopkins Hosp. Date signed: 9/26/48

92D

VS 150

667190

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82a

Registered No. 667190

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3200 Wisteria Avenue
(c) Hospital or Institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ****
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3200 Wisteria Avenue (If rural give location)
(e) Citizen of foreign country? ***** (Yes or No) If yes, name country *********

3 (a) FULL NAME Isaac A. Scopinich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence E. Scopinich
6 (c) If alive, give age ** years

7. Birth date of deceased (mo., day, yr) June 2, 1878

8. AGE: Years	Months	Days	If less than one day
70	3	22	** hr. ** min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Jeweler
11. Industry or business

FATHER
12. Name Mr. Antonio Scopinich
13. Birthplace Austria

MOTHER
14. Maiden Name Lucetta M. Cooper
15. Birthplace Bermuda

16 (a) Informant Mrs. Florence E. Scopinich
(b) Address 3200 Wisteria Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/29/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director H. C. Means and Son
(b) Address 805 N. Calvert Street

19 Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1948, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6 1948, to 9-29 1948, and that I last saw h in alive on 9-27 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Michael Scopinich Jr

Address 3406 Belvl. Rd Date signed 9-28-48

67191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

G67191 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 Scott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Ba ltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 Scott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN CONRAD RAU

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-05-1873

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Nov. 28, 1873

8. AGE: Years 74 | Months 10 | Days - | If less than one day: hr. min.

9. Birthplace Ba ltimore, Md. (Town, county, and state)

10. Usual Occupation Butcher, Retired

11. Industry or business

FATHER
12. Name John Rau
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Schluderberg
15. Birthplace Germany

16 (a) Informant Margaret J. Rau
(b) Address 717 Scott St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/1/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Salem
Location Wilmington, Del

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St

19 SEP 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1948 19 ..., at 12:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 19 48 to 9/28 1948.
and that I last saw him alive on 9/28 19 48.

Immediate cause of death: Acute Cardiac Collapse — Duration: 1da

Due to Carcinoma of Stomach C Metastases — Duration: Mos.

Due to Cardiovascular Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Joseph G Lancaster, M.D.
Address 1217 St. Paul St Date signed 9/28/48

VS 150

192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667192

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2904 Huntingdon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FLOYD ARVILLE AUSTIN

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-07-1458

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1904

8. AGE: Years 43 | Months 11 | Days 29 | If less than one day: hr. min.

9. Birthplace Shenandoah, Va. (Town, county, and state)

10. Usual Occupation Pipe Fitter

11. Industry or business Bethlehem Steel Co

FATHER
12. Name John Edward Austin
13. Birthplace Page Co., Va.

MOTHER
14. Maiden Name Mary J. Pence
15. Birthplace Page Co., Va.

16 (a) Informant Margaret Austin
(b) Address 3101 Puttey Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/48 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Memorial
Location Dorsey, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 29 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1948, at 6 30/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1939, to Sept 28, 1948, and that I last saw h[illegible] alive on Sept 27 1948.

Immediate cause of death: Cerebral thrombosis — Duration:

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack L. Berger, M.D.
Address 50 E. North Ave Date signed 9-28-48

VS 150

67193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

K 67193 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DUKELAND + RAYNER AVES
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 Bryant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Siegel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1871

8. AGE: Years 77 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Russia

MOTHER 14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Irwin Frenkil
(b) Address 3208 Dorchester Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) SEP 29 1948 (Date received by registrar) (b) Filing Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28/48 1948 at 3:10 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/27 1948 to 9/28 1948, and that I last saw her alive on 9/28 1948.

Immediate cause of death Cerebral Hemmorrhage — Duration

Due to Arteriosclerotic Hypertensive Heart Disease

Due to Generalized

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Feldenkrais, M.D.

Address West Balt. 21 Hosp. Date signed 9/28/48

VS 150

67194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G67194

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Esther Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Faunie
15. Birthplace Russia

16 (a) Informant Isaac Miller
(b) Address 2225 No Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2410 Eutaw Place

19 (a) (Date rec'd by registrar) SEP 29 1948 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1948, at 4:46 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20 1948, to 9-28 1948, and that I last saw her alive on 9-28 1948.

Immediate cause of death Pac Carcinoma of breast with liver metastases — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Ecker M. D.
Address Sinai Hosp. Date signed 9-28-48

VS 150

67195

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G67195
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 DIVISION STREET
(c) Hospital or institution: PROVIDENT HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) WIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Harlem avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY EHLEN HOBBY Hobby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	COLORED	MARRIED

6 (b) Name of husband or wife JOSHUA HOBBY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 28th, 1892

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56	-	-		

9. Birthplace BALTIMORE MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name CHARLES MARTIN
13. Birthplace Howard Co, Md.

MOTHER
14. Maiden Name CARRIE WATTS
15. Birthplace MONTGOMERY CO., MD.

16 (a) Informant HUSBAND NEAREST + DAUGHTER
(b) Address 1705 HARLEM AVENUE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location City

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1011 N. Arlington Ave

19 SEP 29 1948 (Date rec'd by registrar) (By) Washington Williams Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28, 1948 at 3:50 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 26 1948 to Sept 28 1948 and that I last saw her alive on Sept 28th 1948.

Immediate cause of death: RETROPERITONEAL HEMORRHAGE — Duration 2 hrs.
Due to ONSET UNDETERMINED
Due to
Other Conditions DIABETES MELLITUS — UNKNOWN
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George McDonald
Address 8449 Early Date signed 9/29/48 (M. D.)

VS 150

103

667196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

667196 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 577 Laurens st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 577 Laurens st. (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Florence Millard

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Louis Millard
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1866

8. AGE: Years 82 | Months 7 | Days 6 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business —

FATHER
12. Name not known
13. Birthplace —

MOTHER
14. Maiden Name Eliza Davage
15. Birthplace Baltimore, Md.

16 (a) Informant Clarence Millard
(b) Address 577 Laurens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-48 (month) (day) (year)
(c) Cemetery or crematory Antrim Mem. Park
Location Balto. Co.

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1011 N. Arlington Ave

19 SEP 29 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9.28.48 19 at 1:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9.17.47 19 to 9.28.48 19, and that I last saw her alive on 9.26.48 19

	Duration
Immediate cause of death: cerebral hemorrhage	Terminal
Due to cardio renal vascular Disease	1947
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature James M Fair M. D.
Address 406 N. Carrollton Date signed 9.28.48

VS 3

7197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 667197

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos. 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 mos. 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (b) County
(c) City or town Jenkintown (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 Hillside Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Bruckner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Emma Bruckner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-23-68

8. AGE: Years	Months	Days	If less than one day
80	0	5	hr. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation Secretary, Credit man
11. Industry or business

FATHER
12. Name John Bruckner
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Dahnatz
15. Birthplace Germany

16 (a) Informant The Seton Institute
(b) Address 6420 Reisterstown Rd. Balto 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-48 (month) (day) (year)
(c) Cemetery or crematory Holy Sepulchre
Location Timonium, Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (U. S. Branch Office) 105 E. Baltimore Avenue

19 (a) SEP 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1948 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16, 1940 to Sept. 28 1948, and that I last saw h l alive on Sept. 28 1948

Immediate cause of death: Coronary occlusion — Duration: 1 day
Due to: Coronary sclerosis
Due to: General arteriosclerosis
Other Conditions: Psychosis with cerebral arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter O. Johnson, M.D.
Address The Seton Institute Date signed Sept. 28 1948

67198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667198

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Streets
(c) Hospital or institution Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 224 E. University Parkway (If rural give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Mrs. Gilbert Allen Jarman (GILBERT ALLEN JARMAN)

MEDICAL CERTIFICATION

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No. 213-01-3984

20. DATE OF DEATH Sept. 28 1948, at 7 50 P M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1948, to 9-28 1948, and that I last saw h/ alive on 9-28 1948

6 (b) Name of husband or wife Marion Jones Jarman
6 (c) If alive, give age 56 years

Immediate cause of death Pneumonia, Left Lower Lobe — Duration

Due to Congestive Failure

Due to Hypertensive Cardiovascular Disease

Other Conditions Leukemia Cirrhosis

(Include pregnancy within 3 months of death)

7. Birth date of deceased (mo., day, yr.) Nov-15-1890

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	10	13		

9. Birthplace Kent Co. Md. (Town, county, and state)

10. Usual Occupation Owner Jarman Motors
11. Industry or business (Automobiles)

PHYSICIAN

Underline the cause to which death should be charged statistically

Date of operation

Major findings of operation:

of autopsy: as above

FATHER
12. Name G. Allen Jarman
13. Birthplace Kent Co. Md.

MOTHER
14. Maiden Name Mary Emma McWhorter
15. Birthplace Riverton, N. J.

16 (a) Informant Mrs. J. Dorsey
(b) Address Mrs. G. A. Jarman 224 E. Univ. Pkwy

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Sept 30-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Stewart Memorial Co.
(b) Address 108 W. North Ave.

19 (a) SEP 29 1948 (Date rec'd by registrar) Huntington Williams, M.D.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury

23. Signature J. Frank Snyder III
Address Union Memorial Hosp Date signed Sept 28, 1948

VS 152

67199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67199

BS-123217

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1911

8. AGE: Years	Months	Days	If less than one day: hr.	min.
37	7	10		

9. Birthplace Centerville, Maryland.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Charles Brooks.
13. Birthplace Centerville, Maryland.

MOTHER
14. Maiden Name Lottie Johnson
15. Birthplace Centerville, Maryland.

16 (a) Informant RECORDS. BALTO CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 2, (month) (day) (year)
(c) Cemetery or crematory Birdsville Cemetery
Location Centerville, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) SEP 29 1948 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 19 48 at 5:30 M A

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23 19 48 to 9-28 19 48 and that I last saw her alive on 9-28 19 48

Immediate cause of death Probable malignant hypertension — Duration 2 wks.

Due to Subacute and acute glomerulonephritis — 4 years

Due to

Other Conditions Pulmonary edema — 3 hr.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Probable glomerulonephritis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 19 48 at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Shutzman
Address Balto. City Hosp. Date signed 9-28-48

VS 159

667200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 927

667200 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Rock Rose Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 Christopher Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara Thaler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 13 1864

8. AGE: Years 84 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Jonny Thaler

13. Birthplace Germany

MOTHER 14. Maiden Name Hoffman

15 Birthplace Germany

16 (a) Informant Mrs Maria Preil

(b) Address 2813 Christopher Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto

18 (a) Funeral director J. E. Hutchinson

(b) Address 3001 Pinkney Ave

19 (Date received by local registrar) SEP 28 1948 Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1948 at 4 P M

21. I certify that death occurred on the date above stated: that I attended deceased from 9-25 1948 to 9-27 1948, and that I last saw her alive on 9-26 1948.

Immediate cause of death: Hemorrhage Intestinal — Duration: 5 days

Due to Arteria Sclerosis

Due to Cardio Vascular disease

Other Conditions [redacted] N.P.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: c

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Ira E. Hatchitt

Address 220 S. Univ Pkwy Date signed 9/25/48

VS 150

67201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 67201

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 Ballou Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 Ballou Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Companion

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 297-10-7034

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Willa H.

6 (c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Dec. 24 1903

8. AGE: Years: 44 | Months: 9 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Charleroi Penna. (Town, county, and state)

10. Usual Occupation: Welder

11. Industry or business

FATHER
12. Name: Oscar Companion
13. Birthplace: Belg.

MOTHER
14. Maiden Name: Mary Glancy
15. Birthplace: Soc.

16 (a) Informant: Willa H. Companion
(b) Address: 221 Ballou Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 1 48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: 4600 - Belair Rd

18 (a) Funeral director: Doppel Bros.
(b) Address: 1800 E. Lombard St.

19 Date received by Registrar: SEP 29 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28 1948 at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1948 to Sept 2 1948, and that I last saw h[illegible] alive on Sept 2 1948.

Immediate cause of death	Duration
carcinomatosis	
Due to Cancer of rectum — operated April 1945	—
Due to	
Other Conditions Ca of Brain — Growth removed Carcin	—

(Include pregnancy within 3 months of death)

Date of operation: Aug 4/45

Major findings of operation: Carcinoma of rectum + Brain

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature: [illegible]
Address 722 N Kenwood Ave Date signed: Sept 29/48

VS 150

7202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667202

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1432 Holbrook Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 28 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 Holbrook Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Florence Darden

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hiram Lester Darden

6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.) July 1st, 1891

8. AGE: Years 57 | Months 2 | Days 25 | If less than one day ########## min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: William Johnson
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Mollie ?
15. Birthplace: Virginia

16 (a) Informant: Mr. Hiram Lester Darden (Husband)
(b) Address: 1432 Holbrook Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: E. North Avenue, Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) SEP 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26, 1948 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 46 to Sept 26 19 48, and that I last saw h alive on 24 Sept 19 48.

Immediate cause of death: Cerebral hemorrhage — Duration: 1 hr

Due to: Essential hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: [illegible] M. D.

Address 714 E. Preston Date signed 24 Sept

V S 150

7203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

667203 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4202 Elsrode Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4202 Elsrode Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William P.H. Schaefer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Minnie T

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12 - 1875

8. AGE: Years	Months	Days	If less than one day
72	11	15	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Minnie Schaefer
(b) Address 4202 Elsrode Ave

17 (a) Burial (b) Date thereof 9-30-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lakewood
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) SEP 29 1948 (b) Signature of Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Sept. 1948 at 3:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 27 Sept 48

VS 151

667204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

667204 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 312 Albemarle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Albemarle St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Lyons

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife xxx James Lyons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30 [illegible]7
If less than one day hr. min.

8. AGE: Years	Months	Days
71 70	3	29

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

MOTHER / FATHER
12. Name William Duffy
13. Birthplace England
14. Maiden Name Mary O'Brien
15. Birthplace England

16 (a) Informant Mrs. Margaret Cherigo
(b) Address 312 Albemarle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. [illegible]st/48 (month) (day) (year)
(c) Cemetery xxxxxx Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 322 S. High St.

SEP 29 1948 (Date rec'd by registrar)
(b) [illegible] Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1948, at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1947 to Sept. 28 1948, and that I last saw her alive on Sept. 28 1948.

Immediate cause of death: Pulmonary Edema — Duration: 1 day
Due to: Left ventricular cardiac insufficiency — 7
Due to: Senile Anemia
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Valentine, M.D.
Address 1732 N. Broadway Date signed 3/28/48

67205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

✓ G67205 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 S. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Albert

3 (b) If veteran, name war | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife Ida
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr) 5-13-81

8. AGE: Years	Months	Days	If less than one day
67	4	15	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Sylvester Albert
13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth ? Blume
15. Birthplace Germany ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director John J Duda
(b) Address 2829 Hudson St.

19 SEP 29 1948 (Date received by registrar) Huntington Williams Mort

MEDICAL CERTIFICATION 35A

20. DATE OF DEATH Sept. 28 1948, at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1946 to 9/28 1946 and that I last saw h alive on 9/28 1946.

Immediate cause of death Pulm. + Card. embolism — Duration, 10 min

Due to Acute thrombosis — 10 days

Due to P.O. stroke

Other Conditions Benign Prost Hypert. Diabetes Mellitus (Include pregnancy within 3 months of death)

Date of operation 9-19-48

Major findings of operation: B.P.H. & Diabetes Gangrene.

of autopsy: Dr. Trow, Dr. Hodden

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Willard C. Brosman M. D.
Address Johns Hopkins Hosp Date signed 2 Oct 48

VS 150

667206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

667206
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1036 N Eutaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1036 N Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Coleman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 4, 1903

8. AGE: Years	Months	Days	If less than one day
45	-	26	hr. min.

9. Birthplace Laurens S. C. (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER 12. Name	Clayton Coleman
FATHER 13. Birthplace	Laurens S. C.
MOTHER 14. Maiden Name	Isabel Burnside
MOTHER 15 Birthplace	Laurens S. C.

16 (a) Informant Osa Coleman
(b) Address 2600 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof September 30 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie A. Williams
(b) Address 322 N. Schroeder St.

SEP 29 1948 (b)
(Date rec'd by registrar) Registrar

Huntington & Williams, Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1948 at 6:44 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1948 to Sept. 27 1948, and that I last saw h[illegible] alive on Sept. 27 1948.

Immediate cause of death Mitral Regurgitation

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence, at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 9/28/48

Type or write the causes of death clearly and legibly.

G67207 ✓ G67207

GM. 123185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals. 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 734½ W. Saratoga ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anderson Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 25- 1874

8. AGE: Years	Months	Days	If less than one day
73	8	29	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business

FATHER
12. Name Isaac Harris (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Ellen ?
15. Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) 1948 (b) (Date rec'd by registrar) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 24- 1948 at 9.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22- 1948 to 9- 24- 1948 and that I last saw him alive on 9- 24 - 48.

Immediate cause of death Malnutrition — Duration months

Due to Carcinoma of the stomach — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma of stomach

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman Cole M.D. M.D.
Address 4940 Eastern Ave Date signed 9/28/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

G67208

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G67208
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 W. 24th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 121 W. 24th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cordelia P. Sumwalt

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1860

8. AGE: Years 87 | Months 11 | Days 0 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Sumwalt
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Ann --
15. Birthplace Pa.

16 (a) Informant Mrs. Florence E. Sumwalt
(b) Address 4307 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9/29/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) SEP 29 1948 (To be filled in by registrar) Huntington Williams

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Sept. 1948, at 3:27 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of R. Breast

Due to

Other Conditions Arteriosclerotic Cardio-Vascular Disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer M.D. Medical Examiner.
Date signed 27 Sept. 48

G67209 ✓ G67209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2437 Reisterstown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2437 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CAPT. JOHN PATRICK McSHANE

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sue Dennis McShane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 12, 1880

8. AGE: Years: 68 Months: 7 Days: 15 If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Balto. City Fire Department

FATHER
12. Name: John T. McShane
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Mary J. Afroux
15 Birthplace: Md.

16 (a) Informant: Mrs. Sue Dennis McShane
(b) Address: 2437 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 28 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1948 at 2:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1948 to Sept 27 1948 and that I last saw him alive on Sept 27 1948

Immediate cause of death: Cardiac failure — Duration:

Due to Carcinoma of Prostate & metastasis to Lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Scagnetti M.D.
Address 1729 W. Lombard St Date signed 9/28/48

Albert Scagnetti ×

667210

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667210 Registered No. 121a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3212 Tremont St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Sophia Roberts
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe.	Negro	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-28-80

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	1	25		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Stansbury
13. Birthplace Md

MOTHER
14. Maiden Name Annie Trust
15. Birthplace Md

16 (a) Informant Hospital Records
(b) Address Provident Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto, Md.

18 (a) Funeral director David L Brownston
(b) Address 1000 Pennsylvania Ave

19 (a) 9-29-1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25-48 (Month) (day) (year) 1:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9-23-1948 to 9-25-1948 and that I last saw h alive on 9-25-1948

Immediate cause of death Coronary occlusion — Duration

Due to Cardiac embarrassment

Due to Generalized arteriosclerosis

Other Conditions Hypertension

(Delete) (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1514 Division St Date signed 9-27-48

VS 151

95c

Cal 2 667211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

115c

667211 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 423 Brentwood Ave
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Morris Tatum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5-6-84

8. AGE: Years	Months	Days	If less than one day
26	4	20	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Tatum

13. Birthplace Va.

MOTHER 14. Maiden Name Susie Farham

15. Birthplace Va

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 29/48 (month) (day) (year)

(c) Cemetery or crematory
Location Petersburg Va.

18 (a) Funeral director Mr. Robert G. Elliott Esq

(b) Address 1129 N. Caroline St

19 (a) SEP 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

05 A

20. DATE OF DEATH 9-28 1948 at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20 1948 to 9-28 1948, and that I last saw h[illegible] alive on 9-28 1948.

Immediate cause of death Polyneuritis +/or encephalitis — Duration

Due to ? diphtheria

Due to ? infectious (post) encephalitis

Other Conditions Palato-pharyngeal paralysis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature William W. Winternitz M.D.

Address Johns Hopkins Hospital 9-28-48

876

VS 150

G67212

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 82a

Registered No. G67212

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 617 N. Castle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 N. Castle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helena M. Clark,

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Robert A. Clark
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1868

8. AGE: Years 79 | Months 10 | Days 17 | If less than one day: hr. min.

9. Birthplace: St. Mary's Co. Md. (Town, county, and state)
10. Usual Occupation: Housewife,
11. Industry or business: at home

FATHER
12. Name: William E. Abell,
13. Birthplace: St. Mary's Co. Md.

MOTHER
14. Maiden Name: Jane Russell,
15. Birthplace: St. Mary's Co. Md.

16 (a) Informant: Miss Anna Mae Clark,
(b) Address: 4948 Denmore Ave.,

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/30/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem
Location: Baltimore, Md.

18 (a) Funeral director: C. Vernon Lemmon.
(b) Address: 4611 Park Heights Ave.

19 (a) 1948 (b) Rec'd by registrar Washington Williams, Registrar
29

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1948 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Prior 19 46 to 9/27 19 48 and that I last saw h alive on 9/27 19 48

Immediate cause of death: Cerebral hemorrhage — Duration: 1 week.
Due to: arteriosclerosis & hypertension — 3 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Harry F. Kane M. D.
Address: 2607 E. Preston St. Date signed

V S 150

X

667213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

667213 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 W Biddle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town City (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 W Biddle St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Roaf

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife Willie Roaf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 30 | Months | Days | If less than one day hr. min.

9. Birthplace Balto City (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Beckett
13. Birthplace Va

MOTHER
14. Maiden Name Elnora Johnson
15. Birthplace Va

16 (a) Informant Willie Roaf
(b) Address 523 W. Biddle St

17 (a) Burial (b) Date thereof 10/2/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Co Md

18 (a) Funeral director Wm J Jackson
(b) Address 916 Penna Ave

SEP 29 1948 (b) Washington D.C.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26/48 19 , at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20/48 to 9/24/48 and that I last saw h[illegible] alive on 9/24/48

Immediate cause of death Pulmonary Embolism
Due to Pneumonia
Due to
Other Conditions Contributing Bronchitis
(Include pregnancy within three months of death)

Duration: Several weeks

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Barksdale M. D.
Address 526 N. Carey Date signed 9/29/48

667214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667214
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Bavard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Oliver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-8-68

8. AGE: Years 80 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Oliver
13. Birthplace ?

MOTHER
14. Maiden Name Mary ?
15. Birthplace ?

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem. Location Brooklyn, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1510 Bloomsbury Ave Baltimore, Md.

19 (a) 9-29-1948 (Date rec'd by registrar) (b) Registrar

VS 150 Released to Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1948 at 10 20A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25 1948, to 9/27 1948 and that I last saw him alive on 9/27 1948

Immediate cause of death: Cerebral hemorrhage
Due to: Hypertensive arteriosclerotic cardio
Due to: vascular disease

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William W. Winternitz, M.D.
Address Johns Hopkins Hospital Date signed 9-27-48

G67215

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G67215 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 496 Brunswick St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 496 Brunswick St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Weddle

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Widowed

6 (b) Name of husband or wife John W. Weddle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1860

8. AGE: Years	Months	Days	If less than one day
88	5	17	hr. min.

9. Birthplace Frederick Co. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Ephriam W. Ridge
13. Birthplace MD.

MOTHER
14. Maiden Name MARTHA EVA DOMER
15. Birthplace MD

16 (a) Informant MRS. ANNABELLE JACOBS
(b) Address 496 BRUNSWICK ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-1948 (month) (day) (year)
(c) Cemetery or crematory Lewistown MD
Location Lewistown Md.

18 (a) Funeral director M. R. Eckman & Son
(b) Address Frederick, Md.

(b) Eckman
(b) rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1948, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1948 to Sept 27 1948.
and that I last saw h[illegible] alive on Sept 27 1948.

Immediate cause of death — Duration
acute Dilatation
Cardio-vascular Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Wellington Williams, M.D.
Address 107 E. Main St. Date signed 29 Sept

667216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

667216 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 27 days
(e) Length of stay in Baltimore (yrs., mos., or days): 27 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Montgomery
(c) City or town: Bethesda (If outside city or town limits, write RURAL and give town)
(d) Street No.: 6608 Clarden Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: NEVA LENORE ELLIS

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr): March 29, 1906

8. AGE: Years	Months	Days	If less than one day
42	6	-	hr. min.

9. Birthplace: Demorest, Ga. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business:

FATHER
12. Name: John E. Ellis
13. Birthplace: Ga.

MOTHER
14. Maiden Name: Neva Marshall
15. Birthplace: Ga.

16 (a) Informan: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 29 48 (month) (day) (year)
(c) Cemetery or crematory: Reynolds Ga
Location: Georgia

18 (a) Funeral director: Williams Cook Inc
(b) Address: 1217 St Paul St

SEP 29 1948 (Date rec'd by registrar) (b) Registrar

Burlington Williams MD

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 29 1948, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2 1948 to Sept. 29 1948, and that I last saw her alive on Sept. 29 1948.

Immediate cause of death	Duration
Metastatic carcinoma (primary site, left breast) involving liver, lung,	8 yrs.
Due to adrenals, bone	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: 1941
Major findings of operation: Mastectomy, radical , left
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 9/29/48

G67217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G67217 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1401 N. Collington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 N. Collington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CLARENCE EDMUND ADAMS

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Cora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1871

8. AGE: Years 77 | Months 0 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Electrician's Helper Retired

11. Industry or business

FATHER
12. Name Edmund Adams
13. Birthplace Bermuda

MOTHER
14. Maiden Name Martha E. Grove
15. Birthplace Maryland

16 (a) Informant Sophia Yeager
(b) Address 1401 N. Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

9 29 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1948 19 , at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 19 48 to Sept 29 19 48, and that I last saw h-- alive on Sept 28 19 48.

Immediate cause of death	Duration
Coronary Embolism	1 hr
Medical Regurgitation	1 yr
Due to Chronic Nephritis	1 yr
Hypertension	1 yr
Due to Chronic Interstitial Nephritis	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 10/2/48

VS 150

7218

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667218

Registered No. 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forrest Street
(c) Hospital or institution: Maryland Penitentiary Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 954 Forrest St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Married

6 (b) Name of husband or wife Lola Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 8, 1904

8. AGE: Years 44 | Months 3 | Days 1 | If less than one day hr. min.

9. Birthplace Braddock, Pennsylvania (Town, county, and state)

10. Usual Occupation Skilled Laborer

11. Industry or business

FATHER
12. Name Walter Wilson (deceased)
13. Birthplace East Indies

MOTHER
14. Maiden Name Lilly Fulton (deceased)
15. Birthplace Hayden, Virginia

16 (a) Informant Deceased
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 23 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 29 1948 (Date rec'd by registrar) (b) [illegible] for William M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Etiology undetermined	
Due to	
Other Conditions: Possible Tuberculosis 2. Hypertensive Cardiovascular disease (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify (y) or (n))
(e) Means of injury

23. Signature Henry W. D. Hollyis, M.D.
Address Maryland Penitentiary Date signed 9/9/48.

107

VS 150

67219

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

G67219
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Eisland Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 45 | Months | Days | If less than one day hr. min

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof

(c) Cemetery or crematory
Location University Medical School SEP 29 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15 1948, at 1 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Lobar Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial plant, in public place? While [illegible]?
(d) Means of injury

23. Signature Frank L. Royster M.D.
Medical Examiner
Date signed

VS 151

667220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. 667220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 1/2
(c) Hospital or institution: Balt. City Hosp. Bad. Asy.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 S. Sharp St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
48			hr min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month, day, year)
(c) Cemetery or crematory
Location University Medical School SEP 23 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Sept 1948, at 2.10 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 22 1/2

(a) Date of injury 9-11-48 at approx. 1.30 p. M.
(b) Where did injury occur? Pier #16, Balto. Md. Light St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial place While at work? yes
(d) Means of injury Found drowned

23. Signature M.D.
Medical Examiner.
Date signed 12 Sept 48

VS 151

G67-21

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67-21 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: BALTIMORE CITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hr. 15min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 Dorn St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles WICKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years 27 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 23 1948 Commissioner of Health

18 (a) Funeral director

(b) Address

19 SEP 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1948, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Edema of brain
Scarring of heart.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/8/48

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667222 (Registered No.) 667222

GM. 123170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 Fusting Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Axer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	D

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
81 ?			hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Axer
13. Birthplace Germany

MOTHER
14. Maiden Name Susanna E. Heck
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2-48 (month) (day) (year)
(c) Cemetery or crematory Rock Spring
Location Forest Hill Md

18 (a) Funeral director Martin Ekunz
(b) Address Jarrettsville Md

SEP 29 1948 (Date received by registrar) (b) Lentington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 29- 1948, at 1.00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9- 22- 1948 to 9- 29- 1948 and that I last saw him alive on 9- 29 - 1948.

Immediate cause of death: Bronchopneumonia — Duration: 5 days.

Due to

Due to Arteriosclerotic heart disease & failure ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David H Marine M. D.
Address Balto City Hosp. Date signed 9-29-48

VS 150

667223

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46

667223
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4413 Annanda Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora E. Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Edmund H
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1-1901

8. AGE: Years	Months	Days	If less than one day
47	6	27	hr. min.

9. Birthplace Texas - Md
(Town, county, and state)
10. Usual Occupation Asst Clerk
11. Industry or business American Stores Co

MOTHER / FATHER
12. Name Unknown Thompson
13. Birthplace Unknown
MOTHER
14. Maiden Name Unknown Unknown
15. Birthplace " "

16 (a) Informant Edmund H Williams
(b) Address 4413 Annanda Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.
18 (a) Funeral director Sullivan Cook Inc
(b) Address 1212 St Paul St.
19 SEP 30 1948 Hunter Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1948, to 9/28 1948, and that I last saw her alive on 9/28/48 19

Immediate cause of death: Pancreatic fistula
Due to Ca of Head of pancreas
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Ca of Head of Pancreas
of autopsy: Pancreatic fistula

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lee N. Kaahn M. D.
Address 3206 N. Hilton Date signed 9/29/48

150

667224

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667224 Registered No. 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County a a
(c) City or town Churchton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Blunt "a"

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) 9-19-1948

8. AGE: Years | Months | Days: 1 | If less than one day: 5 hr. min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation: Child

11. Industry or business

FATHER 12. Name Donald Gray ?
13. Birthplace

MOTHER 14. Maiden Name Mary Blunt
15. Birthplace ?

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 SEP 30 1948 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 00

20. DATE OF DEATH Sept. 19 1948 at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19-1948 to 9-19-1948 and that I last saw h[illegible] alive on 9-19-1948.

Immediate cause of death — **Duration**

atelectasis

Due to Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature a. c. Haring M.D.
Address Johns Hopkins Hosp. Date signed 21-Sept 48

VS 150

667225 Rev 48-20926 667225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 160 c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give Town)
(d) Street No. 1003 Linden Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Hopkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife | 6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-22-48

8. AGE: Years | Months | Days 4 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Hopkins
13. Birthplace .....

MOTHER 14. Maiden Name Rita ?
15. Birthplace .....

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ..... (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory .....
Location .....

18 (a) Funeral director .....
(b) Address .....

19 (a) SEP 30 1948 Huntington Williams, M.D. Address .....
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1948, at 1 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1948, to 9/26 1948 and that I last saw her alive on 9/26 1948

Immediate cause of death Cerebral Hemorrhage — **Duration**

Due to Prematurity

Due to .....

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Harry

Date signed 9 27 48

VS 150

667226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 667226

Please write clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Harford

(c) City or town Belair (If outside city or town limits, write RURAL and give town)

(d) Street No. RFD 2 (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dearborough Baby Boy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/22/48

8. AGE: Years	Months	Days	If less than one day: hr.	min.
	2			

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Merrell Dearborough

FATHER — 13. Birthplace 2

MOTHER — 14. Maiden Name

MOTHER — 15. Birthplace ?

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) SEP 30 1948 Huntington Williams, Md.

(Date received by Registrar) (Address)

VS 150

MEDICAL CERTIFICATION

30

20. DATE OF DEATH Sept. 27 1948 at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1948 to 9/27 1948 and that I last saw h/ alive on 9/27 1948

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, in industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature Paul Pusti M. D.

Address Date signed

667227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

667227 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Light Street
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2240 Tacoma St. Westport
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore MD. Zone 30
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME SUE NEWKIRK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Paul Newkirk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1876

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72	4	10		

9. Birthplace Millville New Jersey
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

MOTHER / FATHER
12. Name Charles Syfer
13. Birthplace Millville New Jersey
14. Maiden Name Sarah Penn.
15. Birthplace Millville New Jersey

16 (a) Informant Mrs. Sara Mueller
(b) Address 2349 Annapolis Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore Maryland

18 (a) Funeral director Mamie Cook Syfer
(b) Address 1600 West North Ave.

19 SEP 30 [illegible] Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1948 at 3:50 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9-27 1948 to 9-28 1948 and that I last saw her alive on 9-28 1948

Immediate cause of death	Duration
MYOCARDIAL INFARCTION	
Due to CORONARY THROMBOSIS	
Due to CORONARY SCLEROSIS	
Other Conditions GENERALIZED ARTERIOSCLEROSIS	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel V. Scalia
Address Co. Balto. Gen. Hospital Date signed 9-28-48

VS 150

667228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164 a

Registered No. 667228

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3940 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES SOLLINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Olga

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Liquor Store

11. Industry or business

FATHER 12. Name Jacob

13. Birthplace Russia

MOTHER 14. Maiden Name Hannah

15. Birthplace Russia

16 (a) Informant Olga Sollins

(b) Address 3940 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-48 (month) (day) (year)

(c) Cemetery or crematory

Location Hebrew Mt. Carmel

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Place

19 (a) SEP 30 (Received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29/48 19 .6 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulation

Due to

Other Conditions Marked Depression

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/29/48 at 5:30 P. M.
(b) Where did injury occur? 506 Light Street
(c) Did injury occur at home, on farm, industrial place, in public place? Place of Business (Whether work?) Yes
(d) Means of injury Himself by Coal Gas

23. Signature John R. Devine M.D. (Medical Examiner.)

Date signed 9/30/48

VS 151

G67229

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ G67229 Registered No.

161c.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Lansdowne (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 Fourth St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Calvin E. Shenton

3 (b) If veteran, name war: **********

3 (c) Social Security Account No. ***** **

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife: Single

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1948

8. AGE: Years	Months	Days	If less than one day: hr.	min.
		4		

9. Birthplace Lansdowne, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Calvin E. Shenton
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Bettie Margaret Barton
15. Birthplace Baltimore Maryland

16 (a) Informant Calvin E. Shenton
(b) Address 123 Fourth A ve. Balto. 27

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29, '48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A.A. County Maryland

18 (a) Funeral director F.B. Wippert & Son
(b) Address 1300 Eutaw Place, 17

19 (a) SEP 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 881

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29. 1948; at 12:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital icterus of newborn

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 9/29/48

G67230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G67230

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 N. Streeper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Meyers
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Pauline Meyers
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Oct 27th 1893

8. AGE: Years	Months	Days	If less than one day
54	11	-	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business Printer.

FATHER
12. Name William Meyers
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margarine Ehrline
15. Birthplace Baltimore

16 (a) Informant Pauline Meyers
(b) Address 721 N. Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1 or (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 3005 Orleans St.

19 (a) SEP 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27- 1948, at 9 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1948, to 9-27 1948, and that I last saw him alive on 9-27 1948.

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Gaber M. D.
Address Linda Haag Date signed 9-28-48

VS 150

67231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 67231

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1233 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1233 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie Richards

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 4th 87

8. AGE: Years 71 | Months 5 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER
12. Name Edw F. Richards
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Conroy
15. Birthplace Md

16 (a) Informant Mrs Mary McComas
(b) Address 1233 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) SEP 30 1948 (Date received by registrar) Huntington Williams, M.D. Registrar, Md (b) Address 5217 Harford Rd. Date signed 9-29-48

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29th 1948 at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Sept 1948, and that I last saw her alive on Sept 21 1948.

Immediate cause of death Coronary thrombosis

Due to Coronary sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Brennan M. D.

VS 150

G672232

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G672232 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1911 Chelsea Road
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 Chelsea Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Joseph Byers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary Elandt
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) December 5, 188?

8. AGE: Years	Months	Days	If less than one day
65	9	22	hr. min.

9. Birthplace Council Bluffs, Kansas (Town, county, and state)
10. Usual Occupation Railway mail clerk,
11. Industry or business retired four months

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Mary E. Byers
(b) Address 1911 Chelsea Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave., Baltimore

18 (a) Funeral director John C. Mitchell's Sons, Etc.
(b) Address 1905 Eutaw Place

19 (a) SEP 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1948, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. M. H. Hammer, M.D. Medical Examiner.
Date signed 28 Sept. 48

VS 151

667233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

667233 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W 40th St
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-8-21 15 years
(e) Length of stay in Baltimore (yrs., mos., or days) 92 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W 40th St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Strother, Mrs Alice H

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
F	W	

6 (b) Name of husband or wife: Rev. Frank M. Strother deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 23-1856

8. AGE: Years	Months	Days	If less than one day: hr.	min.
92	7	6		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business

FATHER
12. Name Dr John W Fletcher Hank
13. Birthplace Springfield Ohio

MOTHER
14. Maiden Name Annie M Keener
15. Birthplace Baltimore, Md

16 (a) Informant Mrs Frances M Hazard Sister
(b) Address 700 W. 40th Street Balto

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 1-1948 (month) (day) (year)
(c) Cemetery or crematory Family Burying Ground
Location Markham Va

18 (a) Funeral director Peter Dire & Chas Sons
(b) Address 223 W Chase St

19 (a) SEP 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29 1948 at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1933 to 9/29 1948 and that I last saw him alive on 9/29 1948.

Immediate cause of death Arteriosclerosis (Senility) Duration 12 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W Grafton Hesperger M. D.
Address 214 Medical Arts Bldg Date signed 9/30/48

VS 150

667234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G67234

667234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Fleetwood Rd
(c) Hospital or institution: Ashburton Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Fleetwood Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Stroney Geass

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 17 1864
8. AGE: Years 83 | Months 9 | Days 12 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James A Geass
13. Birthplace Md

MOTHER
14. Maiden Name Sarah V Geas
15. Birthplace Md

16 (a) Informant Howard W Geass
(b) Address 734 Rockrose Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto Md

18 (a) Funeral director Bostrom Bros
(b) Address 2224 N Charles St.

19 (a) SEP 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1948; at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1948 to Sept 29 1948, and that I last saw h-er alive on Sept 28 1948.

Immediate cause of death: Bronchial Pneumonia — Duration 3d
Due to: Cerebral Thrombosis — 1 yr
Arteriosclerosis + Hypertension — 1 yr
Due to:
Other Conditions: Chronic Tuberculosis Kidney — 1 yr
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Fit Stevens M. D.
Address 2818 Bonford Date signed 9 30 48

V S 150

82a

G67235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67235 Registered No.

1.69

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 429 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES N. RITTER

3 (b) If veteran, name war: W.W. II

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: MARY (Evelyn) Ritter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1915

8. AGE: Years: 33 | Months: 0 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Brakeman

11. Industry or business: Western Md. R.R.

FATHER
12. Name: George Ritter
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: (Unknown) MARY WHITEFORD
15. Birthplace: Unknown

16 (a) Informant: Mrs. Evelyn Ritter
(b) Address: 429 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30, 48 (month)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Philip Herwig & Sons
(b) Address: 2024 Orleans St.

SEP 30 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29, 1948 at 6.40a M

21. I certify that I took charge of the remains described above, held an partial autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hemorrhage due to Evisceration of abdomen (Traumatic) Traumatic amputation of Rt. arm

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-29-48 at approx 4.30 a. M.
(b) Where did injury occur? Port Covington, W.Md.R.R.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial place While at work? Yes
(d) Means of injury: Caught between r.r. cars & dragged

23. Signature: Earl L. Ryder M.D. (Medical Examiner.)
Date signed September 29, 1948

VS 15

667236

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667236 ✓ Registered No. 122a

CERTIFICATION APPROVED BY: J. Huddleson M.D. M. D. CHIEF OR ASST. MEDICAL EXAMINER.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens Ave.
(c) Hospital or institution St. Agnes Hosp. (D. O. A.)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 Allendale Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LULA MAY BURNS

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: female
5. Color or race: white
6 (d) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Howard L. Burns, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1884

8. AGE: Years 63 | Months 8 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Walker
13. Birthplace Md.

MOTHER
14. Maiden Name K. Catherine Walling
15. Birthplace Md.

16 (a) Informant Mr. Howard L. Burns, Jr.
(b) Address 2504 Allendale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Registrar's signature) (b) Huntington Williams M.D. Registrar

SEP 30 1948

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 19 48 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1935 to Sept 28 1948, and that I last saw h m alive on Sept 27 1948.

Immediate cause of death: Cerebral Embolism — Duration: 10 min.
Due to:
Due to: Arteriosclerosis — 2 yrs
Other Conditions: diabetes Mellitus. — 5 years
(Include pregnancy within 3 months of death)

Date of operation 9/6/48
Major findings of operation: ventral hernia lower abdomen
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Gareth Mortimer Jr Med M. D.
Address 2706 St Paul St. Date signed 9/29/48

6672237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. 6672237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Ridgewood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY MARTIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Harvey Snyder Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1868

8. AGE: Years	Months	Days	If less than one day
80	2	26	hr. min.

9. Birthplace Easton, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Muhl
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Ralph W. Martin
(b) Address 102 Ridgewood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 30 1948 (Date rec'd by Reg.) Huntington Williams, M.D. (b) Address 20-1/2 York Rd

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1948, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to Sept 27 1948. and that I last saw her alive on Sept 27. 1948.

Immediate cause of death Cardiac Failure — Duration

Due to Arteriosclerosis

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Huntington Williams, M.D.
Date signed 9-1-48

VS 150

G672238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 672238

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert St.

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Howard

(c) City or town Elkridge Balto (21) (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? Yes (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Marion Bostwick Davis

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: none

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Clara Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1877

8. AGE: Years 71 | Months 8 | Days 1 | If less than one day: hr. min. 29

9. Birthplace New York. (Town, county, and state)

10. Usual Occupation Retired Manufacturer

11. Industry or business

FATHER

12. Name Arthur Davis — dead

13. Birthplace Unknown

MOTHER

14. Maiden Name Mary Bostwick — dead

15. Birthplace Unknown

16 (a) Informant Mr. Marion B. Davis Jr.

(b) Address Elkridge, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1, 1945 (month) (day) (year)

(c) Cemetery or crematory Elkridge Episc. Cem.

Location Eldridge, Md.

18 (a) Funeral director W. J. TICHER & SONS INC.

(b) Address North & Pa. Aves.

19 (a) SEP 30 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Sept 1945, at 11:55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1945 to Sept 25 1945, and that I last saw h[illegible] alive on 25 Sept 1945.

Immediate cause of death Generalized abdominal carcinomatosis

Due to Retroperitoneal tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration

Date of operation Aug. 11, 1945 & Sept. 5, 1945

Major findings of operation: Retroperitoneal tumor, & metastatic ca. of [illegible]

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify)

(e) Means of injury

23. Signature Blanche P. Good

Address Union Memorial Hosp. Date signed 9/29/45

VS 150

667239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

461

667239 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3222 Avon Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert FEHLEISEN

3 (b) If veteran, name war None

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of ~~husband~~ wife Emma Louise Fehleisen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-[illegible]-79

8. AGE: Years	Months	Days	If less than one day: hr.	min.
69	5	14[illegible]		

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Steamship Lines

FATHER
12. Name Louis Fehleisen
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Martin
15. Birthplace Germany

16 (a) Informant Mrs. Edna Wilbur
(b) Address 1700 W St. S.E. Wash, DC.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Baltimore, Md.

18 (a) Funeral director WM. J. FICKER & SONS INC.
(b) Address North & Ra. Aves. Balto. 17, Md.

19 (a) SEP 30 1948 (Date rec'd by registrar) (b) Hunting [illegible] Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 September 1948, at 10[illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Sept 1948 to 28 Sept 1948 and that I last saw h[illegible] alive on 28 Sept 1948.

Immediate cause of death Carcinoma of Recto sigmoid with metastases to lymph nodes — **Duration**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept 21, 1948

Major findings of operation: same as above

of autopsy: same as above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J. Frank Supplee, Jr. M.D.
Address Union Memorial Hosp Date signed Sept 25, 48

VS rso

67240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 67240

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.
(c) Hospital or institution:
Harford Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1211 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NANCY K. IGLEHART

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Dr. J. Howard Iglehart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 1, 1877

8. AGE: Years: 71 | Months: 0 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Sweet Chalybeate Spring, W. Va. (Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business:

FATHER
12. Name: Kinnirey
13. Birthplace:

MOTHER
14. Maiden Name:
15. Birthplace:

16 (a) Informant:
(b) Address:

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/1/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 30 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1948, at 1:00p M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-Nov 1945 to 28-Sept 1948 and that I last saw h[illegible] alive on 25-Sept 1948

Immediate cause of death Coronary Thrombosis — Duration: 1 day
Due to Arterio Sclerotic Cardio Vascular Disease — Duration: Nov-45
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Chas W. Edmunds M. D.
Address 2776 Fleetwood **Date signed** Sept 29 48

VS 150

Medical Examiner's case.

D. O. A.
G67241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 1600

Registered No. G67241

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Halethorpe (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Mayne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/29/48

8. AGE:

Years	Months	Days	If less than one day
—	—	—	9 hr. 30 min.

9. Birthplace Halethorpe Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Mayne
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Englehart
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/48 (month) (day) (year)
(c) Cemetery or crematory Pennsylvania
Location Howard Co Md

18 (a) Funeral director Edgar Marbert
(b) Address Catonsville Md

19 SEP 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150 MEDICAL EXAMINERS CASE

MEDICAL CERTIFICATION

Dead on Arrival

20. DATE OF DEATH Sept. 29 1948, at 5:05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 . and that I last saw h alive on 19 .

Immediate cause of death: Intracranial hemorrhage
Due to Prematurity
Due to
Due to

CERTIFICATION APPROVED BY
Thomas J. Mackie, M.D.
For William H. Kammer, M. D.
CHIEF OR ASST. MEDICAL EXAMINER

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J. N. Lyons
Address Johns Hopkins Hospital 9-29-48

To be Approved by Medical Examiner
Released to Hospital

G67242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95-

Registered No. G67242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 Sidney Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Sidney Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Benny

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Martha A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1889

8. AGE: Years	Months	Days	If less than one day
59	7	21	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business

FATHER
12. Name Geo. S. Benny
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ergenstein
15. Birthplace Md.

16 (a) Informant Mrs. Martha Benny
(b) Address 2205 Sidney Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Jersey, Md

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave

SEP 30 1948 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1948 at 7:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 - 1943, to Sept 28 1948, and that I last saw him alive on 9-28-1948.

Immediate cause of death Coronary thrombosis — Duration unknown

Due to

Due to

Other Conditions Coronary Thrombosis — 8 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Riland M. D.
Address 2532 Edmondson Ave Date signed 9-29-48.

667243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

667243 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Cole St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Cole St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frances C. Reuwer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband ~~or wife~~ Godfred A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1880

8. AGE: Years 66 Months 8 Days 17 If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name Thomas Coop
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Godfred A. Reuwer
(b) Address 1708 Cole St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2 '48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick DR

18 (a) Funeral director Henry A Wiltze
(b) Address 4101 Edmondson AVE

SEP 30 1948 (Date rec'd by Registrar) Washington Witherspoon, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1948 at 2a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1948 to 9/29 1948
and that I last saw h[illegible] alive on 9/29 1948.

Immediate cause of death: Arteriosclerotic heart disease — Duration: 3 yrs
Due to:
Due to: Hypertension
Other Conditions: Cerebral Hemorrhage 2 days
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 1020 Wilkens Date signed 9/30/48

Cert X

VS 150

Physicians: please write the causes of death clearly and legibly. The [illegible] Physicians: please write the causes of death clearly and legibly. The [illegible] should be correctly supplied.

67244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 488

Registered No. 67244

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 622 South Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 South Kenwood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Kleiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Adolph Kleiner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) December 2, 1867

8. AGE: Years	Months	Days	If less than one day
80	9	26	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Frances (Unknown)
15. Birthplace

16 (a) Informant Marie Schifferer
(b) Address 622 S. Kenwood Ave.

17 (a) Burial (b) Date thereof 10/1/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly and Zeiler Inc.
(b) Address 403 South Wolfe St. Balto. Md.

1948 SEP 30 1948 Huntington Williams, M.J.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Sept. 27, 1948 19 at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 48 to 9/27 19 48
and that I last saw h alive on 9/27 19 48

Immediate cause of death Carcinoma Uterus

Duration 4 Yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature A. J. McElwee M. D.
Address 3026 Penna Ave Date signed 9/27/48

VS 150

G67245

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92 D

Registered No. G67245

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5610 Mattfeldt
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5610 Mattfeldt Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Lloyd Ensor

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Eleanor Ensor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 28-1852

8. AGE: Years	Months	Days	If less than one day
96	1	1	hr. min.

9. Birthplace Baltimore Co. Maryland
(Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business Retired 24 years

FATHER
12. Name George Ensor
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Lloyd
15. Birthplace Maryland

16 (a) Informant Miss Nellie V. Ensor
(b) Address 5610 Mattfeldt Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1-1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) SEP 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1948, at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an Aut & Insp thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. McGee M.D.
Medical Examiner.
Date signed Sept 29, 1948

VS 181

G67246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67246

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 714 Colorado Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Colorado Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Linton Stephens

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Annie E. Stephens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 17, 1856

8. AGE: Years	Months	Days	If less than one day, hr.	min.
92	2	12		

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Retired 25 years

FATHER
12. Name Joseph Stevens
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Amanda ---
15. Birthplace Pennsylvania

16 (a) Informant A. L. Stephens
(b) Address 714 Colorado Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Pleasant Hill
Location Baltimore Co., Maryland

18 (a) Funeral director Burge Funeral Home
(b) Address 3631 Falls Road

19 (a) SEP 30 19[illegible] (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29, 1948, at 1.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1948, to Sept 29 1948.
and that I last saw h[illegible] alive on Sept 29 1948

Immediate cause of death
Myocardial infarction
Due to Arteriosclerosis
Due to Cardiac disease
Other Conditions

Duration
10 days
2.

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature [illegible] M. D.
Address 3429 Chantilly Rd. Date signed Sept 30

VS 150

67247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 50

Registered No. 67247

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5313 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha P. Germann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/4/1877.

8. AGE: Years 70 | Months 11 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Virginia. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Germann
13. Birthplace Maryland.

MOTHER
14. Maiden Name Ada Elliott
15. Birthplace Virginia.

16 (a) Informant Hospital Records.
(b) Address St. Agnes Hospital.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Oct. 1 - 1948. (month) (day) (year)
(c) Cemetery or crematory Bethel Cemetery.
Location Alexandria - Va.

18 (a) Funeral director Charles J. Schwob.
(b) Address 3512 - Frederick Ave.

19 (a) SEP 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25, 1948, at 12:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15/ 1948 to 9/25/ 1948, and that I last saw h-r alive on 9/25/ 1948

Immediate cause of death Cardio-Resp. failure - severe diabetes

Due to severe cardiac arrhythmia

Due to acute dilitation of stomach

Other Conditions Breast tumor

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

Duration
Acute

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Johnson Venable Jr. M.D.
Address St. Agnes Hospital Date signed 9/28/48

VS 150

61

G67248

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67248
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catons Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3219 Leeds Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George Ebenwein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Dora A. Ebenwein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-19-1877

8. AGE: Years 71 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland-Baltimore
(Town, county, and state)

10. Usual Occupation Work Worker
11. Industry or business Pittsburgh Plate Glass

FATHER
12. Name August Ebenwein
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Hondreight
15. Birthplace Germany

16 (a) Informant Mr. August Ebenweiz Jr.
(b) Address 438-N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2-'48 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Baltimore-Md.

18 (a) Funeral director Charles J. Schwab
(b) Address 3512-Frederick, Ave.

19 (a) SEP 30 1948 (b)
(Date rec'd by reg'r) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1948, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12 1948, to 9-29 1948, and that I last saw him alive on 9-29 1948

Immediate cause of death CARDIO. RESPIRATORY FAILURE — Duration

Due to CEREBRAL ARTERIOSCLEROSIS
SECONDARY LUES

Due to HEPATIC CIRRHOSIS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cas above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Shaw
Address St. Agnes Hosp Date signed 9/29/48

VS 150

667249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667249

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 W. University Parkway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ***
(e) Length of stay in Baltimore (yrs., mos., or days) 14 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County *******
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. University Parkway
(If rural give location)
(e) Citizen of foreign country? ******* (Yes or No)
If yes, name country

3 (a) FULL NAME Colonel Archibald Francis Commiskey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Haile
6 (c) If alive, give age *** years

7. Birth date of deceased (mo., day, yr) July 4, 1874

8. AGE: Years	Months	Days	If less than one day
74	2	24	** hr. *** min.

9. Birthplace Brooklyn, New York
(Town, county, and state)
10. Usual Occupation Retired Colonel
11. Industry or business U. S. Army

FATHER
12. Name Francis Wm. Commiskey
13. Birthplace New York, N. Y.

MOTHER
14. Maiden Name Margaret McCormick
15. Birthplace New York, N. Y.

16 (a) Informant Mrs. Margaret H. Commiskey
(b) Address 100 W. University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Arlington
Location Virginia

18 (a) Funeral director H. W. Meears and Son
(b) Address 105 E. Calvert Street

19 (a) SEP 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1948, at 11.15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 19 to Sept. 28 1948.
and that I last saw h im alive on Sept. 28 1948.

Immediate cause of death: Coronary occlusion — Duration: Re-cumbance

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Gerr, M.D.
Address 1145 St. Paul St. Date signed 9/30/48

667250

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. 667250

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Presstman St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Hannah Trueman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-1-1894

8. AGE: Years	Months	Days	If less than one day
54		27	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Alfred Trueman
13. Birthplace [illegible] ?

MOTHER
14. Maiden Name Messy Ireland
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Maryland

18 (a) Funeral director Charles E. Law
(b) Address 102 Madison avenue

19 SEP 30 1948 (Date received by Registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1948, at 11:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1948 to 9-28 1948; and that I last saw her alive on 9-28 1948.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension (Essential)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Sherman Mellinkoff M.D.
Address Johns Hopkins Hosp. Date signed 9/29/48

VS 150

667251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

T2a

Registered No. 667251

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 N. Lakewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 N. Lakewood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nicholas C. Lenhoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Julia C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1875

8. AGE: Years	Months	Days	If less than one day
73	7	11	hr. min.

9. Birthplace Baltimore Co, Md. (Town, county, and state)

10. Usual Occupation Commission Merchant

11. Industry or business

FATHER 12. Name Adam Lenhoff

13. Birthplace France

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Mrs. Julia C. Lenhoff

(b) Address 702 N. Lakewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Road #14

19 (a) (b) Huntington Williams, M.D. Registrar

SEP 30 1948

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 19 1948 to Sept. 27 1948, and that I last saw him alive on Sept. 27 1948.

Immediate cause of death: Cerebral apoplexy.

Duration: 9 days

Due to Hypertension.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Leon C. Lenhoff M. D.

Address 701 N. Kenwood Ave. Date signed 9/29/48

49a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 3672252

3672252

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Texas (b) County
(c) City or town Waco -
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Libby Janek Tiez
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Albert -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-22-20

8. AGE: Years 27 | Months 11 | Days 8 | If less than one day: hr. min.

9. Birthplace Texas - (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

MOTHER / FATHER
12. Name Victor Janek
13. Birthplace Texas -
14. Maiden Name Francis Machacek
15. Birthplace Texas

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Sept 30-48 (month) (day) (year)
(c) Cemetery or crematory PENELOPE
Location TEXAS.

18 (a) Funeral director Jake O Nichols Sons
(b) Address Waco Central Pl.

19 SEP 30 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1948 at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1948 to Sept 30 1948 and that I last saw h alive on Sept 30 1948

Immediate cause of death: Embryonal Blastoma of the ovary -
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation September 25, 1948
Major findings of operation: Widespread necrotic tissue in abdomen.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)
(e) Means of injury

23. Signature John Waite Jr. M.D.
Address Johns Hopkins Hosp. Date signed Sept 30 1948

VS 150

G67253 HEALTH DEPARTMENT—CITY OF BALTIMORE 667253

CERTIFICATE OF DEATH

9-D

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2824 Walbrook Ave. St., 15-16 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Anna M. Marcks

If U. S. Veteran specify WAR ...

(a) Residence: No. 2824 Walbrook Ave St., ... Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a. If married, widowed, or divorced (HUSBAND of) (or) WIFE of Martin Marcks

6. DATE OF BIRTH (month, day, year) Aug. 11, 1875

7. AGE Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
73	1	16	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ...

10. Date deceased last worked at this occupation (month and year) ... 11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) Baltimore Md.

FATHER

13. NAME William Russell

14. BIRTHPLACE (city or town) (State or country) Baltimore Md.

MOTHER

15. MAIDEN NAME Athenia Gross

16. BIRTHPLACE (city or town) (State or country) Baltimore Md.

17. INFORMANT Martin Marcks

(Address) 2824 Walbrook Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place Cathedral Date Oct. 6 1948

19. UNDERTAKER Martin Fahey Jr. Sons

(Address) 1827 N. Monroe St.

Sept 30 1948

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 9/28 1948

22. I HEREBY CERTIFY, That I attended deceased from 4/13 1945 to 9/21 1948

I last saw him alive on 9/28 1948 Death is said to have occurred on the date stated above, at 11 p. m.

The principal cause of death and related causes of importance were as follows:

	Duration between onset and death
Myocardial insufficiency	1 hr.
Arteriosclerotic heart disease	3 yr.

Other contributory causes of importance: ...

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) Robert G. Ritter M. D.

(Address) 340 P W Indoor Cem

Registrar. Evangeline Williams, M.P.

OCCUPATION is very important. See instructions on back of certificate.

G67254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67254 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State W.Va. (b) County
(c) City or town Beckley (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM ALFRED HICKS

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maude Hicks

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr) Feb. 1, 1885

8. AGE: Years 63 | Months 7 | Days 29 | If less than one day hr. min.

9. Birthplace Ky. (Town, county, and state)

10. Usual Occupation Miner

11. Industry or business

FATHER
12. Name Alfred Hicks
13. Birthplace Va.

MOTHER
14. Maiden Name Betty Marshall
15. Birthplace Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (b) Date thereof 10/1/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Prince
Location Raleigh Co. W. Va.

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St.

19 (a) (Signature) Huntington Williams, M.D.
(Registered by)
OCT 1 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1948, at 3:35AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14 1948, to Sept. 30 1948, and that I last saw h; alive on Sept. 30 1948.

Immediate cause of death Carcinoma of stomach, postoperative state — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/28/48

Major findings of operation: Carcinoma of stomach

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 9/30/48

Dr Buck's Copy

G67255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 102

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ardleigh N. Hornic
(c) Hospital or institution: 2075 Rockrose Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2075 Rockrose Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Gruber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Mae

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27 1883

8. AGE: Years 65 | Months 5 | Days 0 | If less than one day: hr. min.

9. Birthplace Pennsylvania (town, county and state)

10. Usual Occupation Bar Tender

11. Industry or business

FATHER 12. Name Charles B. Gruber
13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Sarah Eiceman
15. Birthplace Pennsylvania

16 (a) Informant Mrs Anna Bennett
(b) Address 503 East 35th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Frederick Road

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul Street

19 (a) Sept 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Sept 1948 at 9 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Sept 1948 to 29 Sept 1948, and that I last saw him alive on 29 Sept 1948.

Immediate cause of death	Duration
Malignant hypertension	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place or public place? While at work?
(Specify)
(e) Means of injury

23. Signature Walter B. Buck M D
Address 18 E. Eager St Date signed Sept 30 48

X

VS 189

G67256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G67256 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MERCY HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 12

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 HILTON ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY WILSON TOWNSEND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife VIRTIE TOWNSEND

6 (c) If alive, give age NOT KNOWN years

7. Birth date of deceased (mo., day, yr.) JUNE 14, 1888

8. AGE: Years	Months	Days	If less than one day
60	3	16	hr. min.

9. Birthplace PENNA. (Town, county, and state)

10. Usual Occupation SAFETY ENGINEER

11. Industry or business

FATHER
12. Name SAMPSON TOWNSEND
13. Birthplace ENGLAND

MOTHER
14. Maiden Name CATHARINE RISINGER
15 Birthplace NOT KNOWN

16 (a) Informant WIFE
(b) Address 3300 HILTON ST BALTO.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Woodlawn Md

18 (a) Funeral director William Cook Inc
(b) Address 127 St Paul St

30 1948 (Date rec'd by Registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Sept 1948 at 730 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Sept 1948 to 30 Sept 1948. and that I last saw him alive on 30 Sept 1948.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	3 DAYS
Due to PNEUMONIA	3 DAYS
Due to PERITONITIS WITH ABDOMINAL DISTENTION	6 DAYS
Other Conditions POSS. LUNG NEOPLASM	

(Include pregnancy within 3 months of death)

Date of operation 23 Sept 1948

Major findings of operation: STRANGULATED FEMORAL HERNIA, RT.

of autopsy: PNEUMONIA, PERITONITIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Ferris M. D.
Address MERCY HOSP., BALTO. Date signed 30 Sept 1948

G672257

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G672257
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 126 N. Lakewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY CLIFFORD LAUDEMAN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Jennie Huber Laudeman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Apr. 17, 1868
8. AGE: Years 80 | Months 5 | Days 11 | If less than one day hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired Clerk
11. Industry or business: Pennsylvania R. R. Co.

FATHER
12. Name: William H. Laudeman
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Martha A. Hitchcock
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. W. W. Laudeman
(b) Address: 12 Belgrove Rd., Catonsville

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/1/48 (month) (day) (year)
(c) Cemetery or crematory: Union Cem.
Location: Allentown, Pa.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

SEP 30 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 29, 1948, at 12:10a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1948 to Sept 29 1948, and that I last saw him alive on Sept 2 1948.

Immediate cause of death: Myocardial failure — Duration: Sept 29/48
Antecedent myocardial degeneration
Due to: Acute bronchial pneumonia —
Due to: Arteriosclerosis —
Other Conditions: Emphysema —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Louis T. Crumrine M. D.
Address 722 Lakewood Ave. Date signed Sept 30/48

VS 150

G67258

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

G67258

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ..... Lombard & Pine
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Carroll
(c) City or town Mt. Airy
(If outside city or town limits, write RURAL and give town)
(d) Street No. R. F. D. 2
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME CHARLES R. SHOEMAKER

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Thomas I. Shoemaker
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) June 28, 1868

8. AGE: Years	Months	Days	If less than one day
79	3	2	..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Howard Hanson
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Watkins
15. Birthplace Md.

16 (a) Informant Estelle F. Hanson
(b) Address Mt. Airy Md

17 (a) Burial (b) Date thereof 10/2/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Locust Grove Cem.
Location Mt. Airy, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 30 1948
(Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 19 48, at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 19 48, to Sept 30 19 48, and that I last saw h[illegible] alive on Sept 19 48.

Immediate cause of death Cerebral embolism
Due to Coronary Thrombosis
Due to Arteriosclerosis
Other Conditions Diabetes
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury .....
23. Signature .....
Address ..... Date signed .....

667259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

667259 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Bolton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Bolton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LLOYD L. LEITH

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Vera Todd Leith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1884

8. AGE: Years	Months	Days	If less than one day
64	6	9	hr. min.

9. Birthplace Appleton, Wis. (Town, county, and state)
10. Usual Occupation Social Eng.
11. Industry or business

FATHER 12. Name Thomas S. Leith
13. Birthplace Scotland

MOTHER 14. Maiden Name Cora B. Briggs
15. Birthplace Appleton, Wis.

16 (a) Informant Mrs. Vera Todd Leith
(b) Address 2101 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 30 1948 (Date received by registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 1948, at 11:45 P M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to Sept 1948, and that I last saw h[illegible] alive on Aug 1948.

Immediate cause of death (Coronary Thrombosis) Cor. Pulmonale Duration 1 yr
Due to Arteriosclerosis 2 yrs
Due to
Other Conditions Diabetes Mellitus 5 yr.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. H. S. Shilling
Address 2426 Eutaw Pl Date signed 9/29/48 M. D.

M S Shilling - M.D. - 94a

VS 150

667260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ 667260 Registered No.

667260

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 Overhill Road
(c) Hospital or institution:
None
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Always 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 Overhill Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hope Horsey Bissell Jr.

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 212-09-2759

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mary Louise

6 (c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.) June 12, 1895

8. AGE: Years	Months	Days	If less than one day
53 52	3	14	hr. min.

9. Birthplace: Chestertown, Maryland (Town, county, and state)

10. Usual Occupation: Executive Vice President

11. Industry or business: Communications - Radio

FATHER
12. Name: Hope Horsey Bissell
13. Birthplace: Chestertown Maryland

MOTHER
14. Maiden Name: Margaret Spencer Richard
15. Birthplace: Chestertown Maryland

16 (a) Informant: Robert S. Bissell
(b) Address: 4302 Keswick (City)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1 1948 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Taylor Ave. Balto Md

18 (a) Funeral director: Harry M. Cookman, Jones Co
(b) Address: York Rd & Overhill Ave.

19 (a) (b) OCT 1 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1948, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1941, to Sept 29 1948, and that I last saw him alive on Sept 29 1948.

Immediate cause of death: Coronary Thrombosis — Duration: 15 minutes

Due to: Coronary Arteriosclerosis — 7 yrs

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Francis W Bluck M. D.
Address: 1326 St Paul St Date signed 9/30/48

VS 150

X

667261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 667261

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4502 St. Georges ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4502 St. Georges ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maggie Taylor

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	colored	widowed

6 (b) Name of husband or wife unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1. 1877

8. AGE: Years	Months	Days	If less than one day
70	11	1	hr. min.

9. Birthplace Chas. Co. Md. (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER
12. Name Wm Branch
13. Birthplace Chas. Co. Md.

MOTHER
14. Maiden Name Margaret Toger
15. Birthplace Md.

16 (a) Informant Rev. Noble Toger
(b) Address 4502 St. Georges Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/48 (month) (day) (year)
(c) Cemetery or crematory Lincoln
Location Chicago, Ill.

18 (a) Funeral director Wm. T. Chatmon Jr
(b) Address 1701 McCulloh St.

19 OCT 4 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1948 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to Oct 2 1948, and that I last saw him alive on Oct 2 1948.

Immediate cause of death Cardiac Renal Disease — Duration: Years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Kenneth A. Johnson M.D.
Address 2329 Jacques St. Date signed Oct 4 1948

VS 150

667262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. 667262

CN. 119788

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Months
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. City Jail
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steve Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years 70 ? | Months | Days | If less than one day: hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1-48 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cem.
Location Baltimore, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Bloomsbury ave

19 OCI (Date rec'd by Registrar) 1 1948 (b) Huntington Williams, M.D. Address Balto City Hosp

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 19 - 1948 at 7.00PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5- 18 -48 to 9- 19- 1948.
and that I last saw him alive on 9- 19- 1948

Immediate cause of death: Subarachnoid hemorrhage — Duration 1 mo.

Due to Hypertensive Arteriosclerotic Heart Disease — ?

Due to

Other Conditions

(include) pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Mahan Jr. Date signed 29 Sep 48.

Please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city limits, write township, and give town)
(d) Street No. 2 C olvins St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOROTHY WASHINGTON
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
32				

9. Birthplace Accomac Co. Va. (Town, county, and state)
10. Usual Occupation Bar Maid
11. Industry or business

FATHER
12. Name Garfield Washington
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Sarah N Sample
15. Birthplace Va

16 (a) Informant Charles Washington
(b) Address 1104 E Lafayette St

17 (a) Burial (b) Date thereof Oct 1/48
(c) Cemetery or crematory Mt Cabery Cem Cemetery
Location Brooklyn Md

18 (a) Funeral director Chas A Wilson
(b) Address Hanlon Huntington Williams, M.D.

19 (a) (Date received by registrar) OCT 1 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1948, 3 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage of heart and lung
Due to

Other Conditions

22. If an external cause was primary [X] cause of death, fill in the following:
(a) Date of injury Sept. 25/48 2 P.M.
(b) Where did injury occur? In Front of 3[illegible] Forrest St.
(c) Did injury occur at home, on farm, industrial place, in public place? public place No
(d) Means of injury Sharp instrument

23. Signature Carl L Rogers M.D. (Medical Examiner)
Date signed 9/25/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1902

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4939 Reisterstown Road.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH CAUGHY

3 (b) If veteran, name war W. W. I

3 (c) Social Security No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4th 1892

8. AGE: Months 11 | Days 13 | If less than one day: hr. min.

9. Birthplace Washington D. C. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Charles S. Caughy
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Ditzel
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mary Caughy
(b) Address 4939 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/48 (Month)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director Wm Cook Inc
(b) Address 129 St. Paul St.

19 (a) OCT 1 1948 (Date rec'd by registrar) Huntington Wills (Local registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1948 at 11:35 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Injury, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Comp. Fracture of right tibia and fibula, Fract. skull, Contusion of brain, Intracranial hemorrhage, Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing [ ] cause of death, fill in the following:
(a) Date of injury 9-21-48 at Approx. 1 A. M.
(b) Where did injury occur? Reisterstown Road 100' south of Arbutus Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public (Whether work) no
(d) Means of injury Pedestrian struck by auto.

23. Signature George P. Merrill M.D.
Medical Examiner.

Date signed 9-28-48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1186

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo. 22da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 N. Spring St. (If rural give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Mrs. Marie Powers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe.	White	Widow

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased: mo., day, yr. June 24, 1848

8. AGE: Years 100 | Months 2 | Days 6 | If less than one day: hr min

9. Birthplace Mt. Savage, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Maxwell
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, Cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19. (a) OCT 1 1948 (Date rec'd by registrar) Huntington, W. Va. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1948, at 12:35 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/5 1948 to 9/30/ 1948, and that I last saw her alive on 9/30 1948

Immediate cause of death	Duration
Hypostatic pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

CERTIFICATION APPROVED BY
Howard Kelly, M.D.
for Mrs. S. Hayes M.D.
CHIEF OR ASST. MEDICAL PHYSICIAN

Underline the cause to which death should be charged statistically

Date of operation
Major findings of operation
of autopsy:

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County)
(d) Did injury occur about home, on farm, industrial place or public place? While at work?
(e) Means of injury abrasions and

23. Signature Anthony F. D. Pauka
Address St. Joseph's Hospital signed 9/30/48

57266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. (1657 Cnty)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3409 Woodbrook Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 3409 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Markowitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased mo., day., yr.

8. AGE: Years 60 Months Days If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Aug. Goldstein

13. Birthplace Russia

MOTHER 14. Maiden Name Lebegen

15. Birthplace Russia

16 (a) Informant Harry Markowitz

(b) Address 3409 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Place

19 (a) OCT 7 1948 (Date rec'd by registrar) Huntington Williamsville, W. Va. (b) Address 276 Eutaw Pl. Date signed 10-4-48

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30-48 4 P.M.

21. I certify that I last attended deceased from July 21 '48 to July 28 '48 and that I last saw deceased alive on July 28 '48

Immediate cause of death

Duration

(a) Cerebral Thrombosis 1 month

Due to (b) Alzheimer Disease 3 months

Due to

Other Conditions

Date of operation Aug 7, 1941

Major findings of operation

Dilated Fundus Glaucoma

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at Work

(e) Means of injury

23. Signature [illegible] M.D.

PHYSICIAN

I hereby certify that the above is true to the best of my knowledge and belief. I have charged the usual fees.

VS 150

67267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67267

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2703 No Hilton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 No Hilton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin [redacted] Hartz
3 (b) If veteran, name war
3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30-1948 at 5 A M

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Cecilia

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. (51)

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state or country)

10. Usual Occupation Manufacturer

11. Industry or business

FATHER 12. Name Harris, L.
13. Birthplace Russia

MOTHER 14. Maiden Name Celle
15. Birthplace Russia

16 (a) Informant Cecilia Hartz
(b) Address 2703 No Hilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-48 (month) (day) (year)
(c) Cemetery or crematory
Location Herring Run

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place

OCT 1 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to 9-30 1948
and that I last saw h alive on 9-30 1948

Immediate cause of death
Coronary Thrombosis
Coronary Insufficiency
Duration: IMM. 3 YRS

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alvin S. Hartz MD
Address 5443 Park Heights Ave Signed 9/30/48

VS 150

67268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67268

Registered No.

157 E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ill. (b) County
(c) City or town Wheaton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 940 College Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jo Nell Frizen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-15-48

8. AGE: Years 7 Months Days 15 If less than one day hr. min

9. Birthplace Ill. (Oak Park)
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Bernard Frizen
13. Birthplace Ill.

MOTHER
14. Maiden Name Berent F. Alfors
15. Birthplace Ill.

16 (a) Informant G. Berent Frizen
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-2-48 (month) (day) (year)
(c) Cemetery or crematory
Location Chicago, Ill.

18 (a) Funeral director John C. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

OCT 1 1948 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1948 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1948 to 9/30 1948, and that I last saw her alive on 9/30 1948

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Congenital Heart Disease	
Due to Pneumonia Bronchial	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept 30, 1948

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(e) Means of injury

23. Signature D. F. Cooley M.D.
Address Johns Hopkins Hospital Date Sept 30/48

VS 150

67269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 131a

Registered No. 67269

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Rockwood Ave #15 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

3 (a) FULL NAME Reinhold Wm. Dykeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Nora Pearl Schaeffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 16, 1887

8. AGE: Years	Months	Days	If less than one day
60	11	13	hr. min.

9. Birthplace Denmark (Town, county, and state)
10. Usual Occupation Manufacturer
11. Industry or business couplings

FATHER
12. Name Wm. Dykeman
13. Birthplace Denmark

MOTHER
14. Maiden Name Sophie M. Jensen
15. Birthplace Baltimore Md.

16 (a) Informant Wm. Dykeman
(b) Address 4200 Falls Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 45 (month) (day) (year)
(c) Cemetery or crematory Krieders Cemetery
Location Westminster Md.

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1 E. Eutaw Pl.

19 (a) [illegible] (Date rec'd by registrar) Huntington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1945 at 7 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1945 to Sept 29 1945 and that I last saw him alive on Sept 29 1945

Immediate cause of death	Duration
Pneumonia, Lobar	
Due to Uremia	
Due to Hypertension - Renal Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Blank M.D.
Address Maryland General Date signed 9/29/45

VS 150

X

67270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

193 ✓

Registered No. G67270

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Key Highway
(c) Hospital or institution Beth. Steel Company 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Ramsay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAUNDERS G. BINGHAM

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Bessie J. Bingham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1910

8. AGE: Years 38 | Months 7 | Days 11 | If less than one day: hr. min.

9. Birthplace Pineville, Kentucky
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Beth. Steel Company

FATHER
12. Name Elias Bingham
13. Birthplace Kentucky

MOTHER
14. Maiden Name Julia Hampton
15. Birthplace Kentucky

16 (a) Informant Bessie J. Bingham
(b) Address 1507 Ramsay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Robt G B M Walker
(b) Address Brady & Tucker Co

19 OCT 1 1948 Huntington, W. Virginia
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30, 1948 at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Electrocution

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-30-48 Approx. 7:30 A.M.
(b) Where did injury occur? Beth Steel Co: [redacted] Key Highway
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Electrocuted while testing electric drill

23. Signature [signature] M.D.
Medical Examiner.
Date signed 9/30/48

VS 151

G67271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. G67271

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Jordon Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT WRIGHT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Sparated

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June(?) 1908

8. AGE: Years: 40 | Months | Days | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: ?
13. Birthplace: Va.

MOTHER
14. Maiden Name: ?
15. Birthplace: Va.

16 (a) Informant: Pharoah Adams
(b) Address: 100 Park Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: Adolphus Halstead

18 (a) Funeral director: 918 Druid Hill Avenue
(b) Address

19 (a) OCT 1 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25, 1948, at 3 20 P/M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Stab wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-25-48 at Approx. 2:00 P. M.
(b) Where did injury occur? 921 Linden Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Friend's Home While at work? No
(d) Means of injury: Sharp Instrument

23. Signature: Earl L. Kyle M.D. Medical Examiner.
Date signed 10-1-48

VS 151

G67272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G67272

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 140 N Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife late Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1856

8. AGE: Years	Months	Days	If less than one day
92			min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Abraham Goodman
13. Birthplace Poland

MOTHER
14. Maiden Name Millie ?
15. Birthplace Poland

16 (a) Informant Charles D Weisberg
(b) Address 3413 Copley Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 OCT 1 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

6.45

20. DATE OF DEATH October 1 1948, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1947 12 to Oct. 1 1948.
and that I last saw h alive on Sept 30 1948

Immediate cause of death Contract Coronary Arteriosclerosis — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Meeen B Fink

Address 3320 Eutaw St Date signed 10/1/48

VS 150

67273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G67273 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Ellamont St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Ellamont St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUSAN E. WEEKS

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Samuel H. Weeks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 16, 1878

8. AGE: Years	Months	Days	If less than one day
70	5	13	hr. min.

9. Birthplace Emory Church, Harford Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jonas Huff
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Arnold
15 Birthplace Md.

16 (a) Informant Mr. Samuel H. Weeks
(b) Address 1511 Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 1 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1948, at 9:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29 1948. to Sept. 29 1948. and that I last saw her alive on Sept 29 1948.

Immediate cause of death	Duration
Coronary thrombosis	one day
Due to (a) not known (emotional upset)	
Due to	
Other Conditions None for autopsy (b) Transient hypertension	two yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice E. Shamer M. D.
Address 3300 W. Fourth Ave Date signed 10/1/48

67274

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 67274

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 Otterbin St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Julia Washington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Femal	Col.	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 2, 1896

8. AGE: Years	Months	Days	If less than one day
52 5I	5	26	hr. min.

9. Birthplace Georgetown S.C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name James Washington
13. Birthplace Georgetown S.C.

MOTHER
14. Maiden Name Eleanor Simmons
15 Birthplace Georgetown S.C.

16 (a) Informant Eloulse Parker
(b) Address 313 Otterbin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. I. 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Brooklyn Md.

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brantly Ave

19 (a) OCT 1 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28 1948, at 24 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 1948 to 9/28 1948, and that I last saw h alive on 19

Immediate cause of death: Chronic Cardio Vascular Pulmonary Disease — Duration: 8yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 90 Huntington Ave Date signed 10/1/48

VS 150

67275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 W. University Pky
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 W. University Pky (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Moale Jenkins

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Chas. V. Jenkins

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Dec 31 1859

8. AGE: Years 88 | Months 9 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Charles H Simmons
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Emily L. Moale
15. Birthplace Balto Md.

16 (a) Informant Mrs Judith M Warner (daughter)
(b) Address 615 W University Pky

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Sullivan Memorial
(b) Address 108 W Mt Royal Ave

19. Filed OCT 1 1948 (Date rec'd by Registrar) Huntington Williams, Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 September 1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from February 1946 to September 1948, and that I last saw h[illegible] alive on 30 September 1948.

Immediate cause of death: bronchiectasis chronic, rt — Duration several years

Due to

Due to

Other Conditions: General muscle atony senile debility, arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy none.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Randall Smith, Jr.
Address 623 W. University Pkwy Date signed 9/30/48

VS 150

Physicians: please write the cause of death clearly and legibly.

G67276 BC = 48-4228 ✓ G67276 ✓

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 107

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 4½ months.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Maryln Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JEAN CARROLL GARMAN

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1o, 1948

8. AGE: Years | Months: 4½ | Days: 1 | If less than one day: hr min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Charles Ambrose Garman
13. Birthplace Penn.

MOTHER
14. Maiden Name Dorothy McKolon
15. Birthplace Md.

16 (a) Informant RECORDS* BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/48 (month) (day) (year)
(c) Cemetery or crematory Christ Lutheran Church Cem.
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 OCT 1 1948 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1948, at 12:40 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-29 1948 to 9-29 1948, and that I last saw her alive on 9-29- 1948

Immediate cause of death: Pneumonia — Duration: 6-8 hrs.
Due to: Septicemia — 6-8 hrs.
Due to: organism unknown
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William P. Kean M. D.
Address Baltimore City Hosp. Date signed 9-30-48

VS 159

67277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

Registered No. 667277

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3213 Shannon Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3213 Shannon Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET BYUS

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	None	F	W	Widow

6 (b) Name of husband or wife Charles A. Byus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1880

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	1	16		

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Gearish
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Bennett
15. Birthplace Germany

16 (a) Informant Mr. Stanley A. Byus
(b) Address 3213 Shannon Drive

17 (a) Burial (b) Date thereof 10/1/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location. Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 OCT 1 1948 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 48 11 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 24 19 48 to Sept 28 19 48.
and that I last saw her alive on Sept 28 19 48

Immediate cause of death
Uremia — Duration 5 days
Due to chronic glomerular nephritis — years
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frankie F. Fiske M.D.
Address 1105 St Paul St Date signed Oct 2 1948

VS 150

67278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G67278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 Marshall St. (SOUTH) (If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN F. BURK SR.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-0720

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWED

6 (b) Name of husband or wife FLORENCE BURK
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 9 - 4 - 1883

8. AGE: Years	Months	Days	If less than one day
65	--	24	---hr.------ min.

9. Birthplace WILMINGTON DELAWARE (Town, county, and state)
10. Usual Occupation WATCHMAN
11. Industry or business BAKER WHITTING COAL CO

FATHER
12. Name JOHN BURK
13. Birthplace DELAWARE

MOTHER
14. Maiden Name ALVERTA LEPPY
15. Birthplace MARYLAND

16 (a) Informant MRS. ROBERT HAIRSINE (DAUGHTER)
(b) Address 1228 S. MARSHALL STREET

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 2/48 (month) (day)
(c) Cemetery or crematory LOUDON PARK CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director F.B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE ..17

19 OCT 1 1948 Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1948 at 9:55 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
Include pregnancy within 3 months of death

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil H. Beyer M.D.
Medical Examiner
Date signed

X

67279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1243

Registered No. 67279

Please write plainly and report the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 Patapsco Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLETCHER COX

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband/wife: Gardenia Melva Cox

6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) March 7, 1910

8. AGE: Years 38 | Months | Days | If less than one day: hr. min.

9. Birthplace Florida
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name William Fletcher Cox
13. Birthplace North Carolina

MOTHER
14. Maiden Name Susan Partilen
15. Birthplace Georgia

16 (a) Informant Mrs Gertrude M. Cox
(b) Address 626 Patapsco Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10/2/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Annapolis Blvd.

18 (a) Funeral director John F. Denny Inc
(b) Address 715 Light St.

19 OCT 1 1948 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29/48 at 8 40 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 7/20/48 to 9/29/48 and that I last saw him alive on 9/29/48

Immediate cause of death (1) Shock — Duration

Due to (2) Hemorrhage

Due to (3) Ruptured Esophageal Varix

Other Conditions (4) Portal Cirrhosis
(5) Eczematoid dermatitis
(Unless pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: (3) + (4)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature William T. Hawn, M.D.
Address South Baltimore Gen Hosp Date signed 9/30/48
Baltimore 30, Md.

VS 753

667250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 667250

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 Milford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTHONY O'NEILL PRENDERGAST

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-10-7330

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hanorah K. Prendergast

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1906

8. AGE: Years 42 | Months 7 | Days 7 17 | If less than one day: hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business James Robertson Mfg. Co.

MOTHER / FATHER

12. Name John A. Prendergast

13. Birthplace Baltimore, Maryland

14. Maiden Name Anna O'Neill

15. Birthplace Ireland

16 (a) Informant: Mrs. Hanorah K. Prendergast

(b) Address 3604 Milford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2, 1948 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Maryland

18 (a) Funeral director E. Willis Lamoreau

(b) Address 4510 Liberty Heights Avenue

19 OCT 1 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29, 1948, at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ✓, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured neck.
Fractured skull.
Intracranial hemorrhage.
Contusion of brain.
Fracture of femur.
Rupture of aorta.
Ruptured diaphragm.
Fractured ribs and facial bones

(Include pregnancy within 3 months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-29-48 at 1:20 P. M. 4/1

(b) Where did injury occur? 106 Hopkins Place

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes

(d) Means of injury Fell down elevator shaft

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 9/30/48

VS 151

G67281

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 121a

Registered No. G67281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County [illegible]
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8808 Ridge Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles High

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Laura L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-19-85

8. AGE: Years	Months	Days	If less than one day
62	10	10	hr. min.

9. Birthplace Balto. Md. (Town, county and state)
10. Usual Occupation Plumber
11. Industry or business H.B. Kiel

FATHER
12. Name Alfred Hugh
13. Birthplace Balt

MOTHER
14. Maiden Name [illegible]
15. Birthplace Alice Roughgarden Balto.

16 (a) Informant Mrs Ruth Kline
(b) Address E. Joppa Rd Fullerton Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 OCT 1 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1948 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27-1948 to 9-29-1948 and that I last saw him alive on 9-29-1948.

Immediate cause of death Respiratory failure — Duration 6 hrs.
Due to Cardiac Decompensation — Duration 8 hrs
Due to Arterial hypertension — Duration 10 yrs
Other Conditions Anuria
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury
23. Signature Alfred Judd M.D.
Address Mercy Hospital Date signed 9-29

VS 150

83a

G67282

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 128

G67282
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles Street
(c) Hospital or institution:
Doctor's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3031 Shannon Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ADAM R. WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr) December 4, 1908

8. AGE: Years	Months	Days	If less than one day
39	9	25	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Proprietor
11. Industry or business Tavern

FATHER
12. Name Walter Bialoskurski
13. Birthplace Poland

MOTHER
14. Maiden Name Ksawera Wasniewska
15. Birthplace Poland

16 (a) Informant Mrs. Elizabeth White
(b) Address 3031 Shannon Drive

17 (a) Burial (b) Date thereof 10/2/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 (a) OCT 1 1948 Washington Metropolitan
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1948, at 3 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26- 1948, to 9-29 1948.
and that I last saw h in alive on 9-29 1948.

Immediate cause of death
Acute Pancreatitis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
5 days

Date of operation 9-27-48
Major findings of operation:
Acute Pancreatitis & Peritonitis
of autopsy: general

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 5707 Belair Rd Date signed 9-30-48

VS 150

important: physicians: please write the causes of death clearly and legibly.

G67283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 P

Registered No. G67283

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: MARYLAND GEN. HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 E. Overlea Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME MRS. BARBARA LONG

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife WALTER LONG
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) SEPT 17, 1880

8. AGE: Years	Months	Days	If less than one day
68	0	12	hr. min.

9. Birthplace AUSTRIA (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business —

FATHER
12. Name JOHN POSPOSL
13. Birthplace BERLIN, GERMANY

MOTHER
14. Maiden Name BARBARA SMITHSEL
15. Birthplace BOHEMIA

16 (a) Informant HUSBAND
(b) Address SAME AS DECEASED

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood 10/4/48
Location Baltimore, Md.

18 (a) Funeral director Lansdowne Funeral Home
(b) Address 7601 Belair Rd.

19 (a) OCT 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 SEPT 1948, at 7.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 20 SEPT 1948 to 30 SEPT 1948 and that I last saw HER alive on 30 SEPT 1948.

Immediate cause of death CARDIORESPIRATORY FAILURE
Due to CARCINOMA OF THE STOMACH WITH WIDE-SPREAD PERITONEAL METASTASIS, JEJUNAL OBSTRUCTION, AND MARKED CACHEXIA
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: EXTENSIVE ABDOMINAL CARCINOMATOSIS

Duration: 2 hours; 1 YEAR?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Donald L. England M. D.
Address Maryland Gen. Hosp. Signed 30 Sept 48

VS 153

G67284

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

Registered No. G67284

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1503 Bentlow St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Bentlow St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ANN YOB.

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	WIDOWED

6 (b) Name of husband or wife VIRGIL YOB
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 4, 1897

8. AGE: Years	Months	Days	If less than one day
51	7	27	hr. min.

9. Birthplace Shamokin, Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Celeste Menagace
13. Birthplace Tyrol, Italy

MOTHER
14. Maiden Name Celesta Pasquin
15 Birthplace Tyrol Italy

16 (a) Informant Leonard Yob
(b) Address 1503 Bentlow St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 1-48 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Mt Carmel Penna

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St Baltimore

19 (a) OCT 1 - 1948 (Date rec'd by registrar) (b) Huntington Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1948. at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1948 to Oct 1 1948.
and that I last saw her alive on Sept 30 1948.

Immediate cause of death	Duration
Cardiac Respiratory Failure	12 hrs
Due to Metastatic Carcinoma	5 mos
Due to Carcinoma of the Breast, Bilateral	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul R Ziegler M. D
Address 3723 Edmondson Ave Date signed

VS 150

667285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp., Bal. (Room)
(d) Length of stay in hospital or inst. (yrs., mos., or days) about 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County
(c) City or town Fairmont
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Aubrey Moore

3 (b) If veteran, name war

3 (c) Social Security Account No. 205-03-6729

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Separated

6 (b) Name of husband or wife Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1905

8. AGE: Years 43 | Months 10 | Days 20 | If less than one day: hr. 1 | min.

9. Birthplace Meadville (Town, county, and state) Pa

10. Usual Occupation Yard Conductor & Master

11. Industry or business B & O R.R.

PARENTS
12. Name of father: Okey J. Moore
13. Birthplace of father: W Va
14. Maiden Name of mother: Minnie Watkins
15. Birthplace of mother: W Va

16 (a) Informant: M. L. Moore
(b) Address: Fairmont W Va

17 (a) Burial, cremation or removal: Fairmont (b) Date thereof (month) (day) (year): 10/1/48

(c) Cemetery or crematory: Fairmont W Va
Location: Fairmont W Va

18 (a) Funeral director: Wilbert Moore
(b) Address: 124 Pt Court St

19 (a) (Date rec'd by registrar) OCT 1 - 1948 Burlington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30 1948, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1948, to 9/30 1948, and that I last saw him alive on 9/30 1948.

	Duration
Immediate cause of death Peripheral Vascular Collapse	
Due to Cardiac failure while undergoing op. for metastic	
Due to Carcinoma to Stomach	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/30/48

Major findings of operation: Metast. Ca [illegible]

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature [signature] M.D.
Address University Hosp. Date signed

VS 150

67286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 67286

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Hosp. Home Maryland
(d) Length of stay in hospital or inst. (~~yrs.~~, ~~mos.~~, or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town White Marsh
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Chandler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
87	4	—	hr. min.

9. Birthplace Not known (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Chandler
13. Birthplace Not known

MOTHER
14. Maiden Name Elizabeth Coffee
15. Birthplace Not known

16 (a) Informant: Leonard Birchead
(b) Address Annville - Maryland

17 (a) Removal (b) Date thereof Oct 2, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurel Hill
Location Philadelphia, Pa.

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address 4905 York Rd.

19 (a) OCT 1 - 1948 Washington [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 30 - 1948, at 2 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept - 27 1948, to Sept - 30 1948, and that I last saw h[illegible] alive on Sept - 30 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Myocardial Infarction	2 weeks
Due to Arteriosclerosis generalized	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Myocardial Infarction

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 10-1-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied.

VS 150

067287

GM. 123047

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82a

Registered No. 067287

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 Hughes ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Hudson (William Henry Hudson)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? ? ?

8. AGE: Years 58 ? Months Days If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? William H. Hudson
13. Birthplace ? Va.

MOTHER
14. Maiden Name ? Martha
15. Birthplace ? Va.

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof Oct 2 1948 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cemty
Location Balto.

18 (a) Funeral director Balto B. Bruce
(b) Address 19? W. Hamburg St.

19 OCT 1 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9- 18 - 1948, at 9.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9- 17 - 1948, to 9- 18 - 1948, and that I last saw h im alive on 9-18- 1948.

Immediate cause of death CEREBRAL HEMORRHAGE — Duration ???
Due to PNEUMONIA RT. LUNG — ???
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. P. Jernigan, M.D.
Address BALTIMORE CITY HOSP Date signed 10-1-48

VS 150

667288

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

667288

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4010 Woodlea Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Woodlea Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MRS IDA KEYS LAWLOR

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife William Andrew Lawlor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
About 70				

9. Birthplace Anderson, S. C. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wm Walters Keys
13. Birthplace South Carolina

MOTHER
14. Maiden Name Vashti Burriss
15. Birthplace South Carolina

16 (a) Informant Com. Wm K. Lawlor
(b) Address 4010 Woodlea Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10/3/48 (month) (day) (year)
(c) Cemetery or crematory
Location Greenville, S. C.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

19 OCT 1 1948 (Date rec'd by Local Reg.) Burlington Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1st 1948, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ~~Oct~~ Sept. 28 1948, to Oct. 1st 1948, and that I last saw her alive on Sept 28 1948.

Immediate cause of death Cancer, metastatic — Duration six months
Due to Cancer, breast — 8 years
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ferdinand E. Christe M.D.
Address 1300 N. Calvert St. Date signed Nov. 1 1948 Balto. 2, Md.

VS 15.

G67289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67289

1. PLACE OF DIATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 239 days
(e) Length of stay in Baltimore (yrs., mos., or days) 239 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Abingdon
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RUSSELL EUGENE CORRELL

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No. 218-09-8676

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of ~~husband or~~ wife Amelia Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 9, 1883

8. AGE: Years 65 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation Draftsman

11. Industry or business

FATHER
12. Name John Correll
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden Name Alice Sluss
15. Birthplace Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Cemetery ~~crematory~~ Lorraine
Location Woodlawn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) OCT 2 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1948, at 11:57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 1948 to Sept. 30 1948, and that I last saw him alive on Sept. 30 1948.

Immediate cause of death Carcinoma, epiglottis with metastases to cervical lymph nodes and

Due to tissue of left side of neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration 1½ yrs

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 10/1/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 67290

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hamptnett Ave.
(c) Hospital or institution: Pine Ridge Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yr. 11 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3427 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Ines Emma Stange

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William Stange

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 19 1862

8. AGE: Years 82 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER 12. Name William Schetlick

13. Birthplace Germany

MOTHER 14. Maiden Name Pauline Bentzahel

15. Birthplace Germany

16 (a) Informant Mrs. Mary Lehr

(b) Address 5110 Wesley Ave Howard Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4 1948 (month) (day) (year)

(c) Cemetery or crematory St. Matthews Bens.

Location Baltimore Md.

18 (a) Funeral director Mamie Cook Syfer

(b) Address 1433 W. North Ave

19 OCT 2 1948 Registrar Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1948 at 3-35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1943 to Sept 30 1948. and that I last saw her alive on Sept. 30 1948.

Immediate cause of death Uremia — Duration 3 mos

Due to nephrosclerosis and arteriosclerosis — years

Due to Diabetes — many years

Other Conditions Hypertrophic auricular fibrillation 3 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ethel Luetscher

Address 12 E Eager St Balto 15 Date signed Oct 2 1948 M. D.

VS 133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 667291

667291

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2919 W Northave 16
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write (U) or (R) and give town)
(d) Street No. 2919 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma R Kerr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife Anthony J Kerr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24 1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
74	10	6		

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Housewife

FATHER
12. Name James T Hickey
13. Birthplace England.

MOTHER
14. Maiden Name Sarah Fox.
15. Birthplace Pa.

16 (a) Informant Anthony J Kerr.
(b) Address 2919 W Northave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4 48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md.

18 (a) Funeral director Lohr & MacNabb
(b) Address Catonsville Md.

19 OCT 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1948. at 11 30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1948. to Sept 30 1948. that I last saw h[illegible] alive on Sept 29 1948.

Immediate cause of death: Coronary thrombosis — Duration about 3 days

Due to arterio-sclerosis — ?

Due to

Other Conditions Diverticulitis - (Colon) — 2 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Stabler M. D.
Address 220 Garrison Blvd. Date signed Oct 2 48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. 1667292

1667292

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7hr. 40min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE M. MARKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife John F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 26, 1888

8. AGE: Years	Months	Days	If less than one day
59	11	5 6	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business home

FATHER
12. Name Henry Hiltner
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Wagner
15. Birthplace Baltimore, Maryland

16 (a) Informant John F. Markins
(b) Address 1224 W. Cross Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3891 Frederick Avenue

18 (a) Funeral director JOHN J. COWAN & SON
(b) Address 901-03 Hollins Street

19 (a) OCT 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams Mor

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1948, at 1:40 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 3rd° Burns 80% Body

Due to

Other Conditions Epilepsy

(Include pregnancy within 3 months of death)

22. If an external cause was primary X, or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/30/48 X 5:30 P. M.
(b) Where did injury occur? 1224 W. Cross Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home (Specify in each case)
(d) Means of injury Had epileptic attack & fell into lighted stove

23. Signature John Edwards, M.D. Medical Examiner.
Date signed 10/1/48

VS 151

67293

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

5 E

Registered No. 67293

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County BWI
(c) City or town Trinidad (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Duke St (If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Spain

3 (a) FULL NAME Michael Sun Soy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	yellow	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/10/40

8. AGE: Years	Months	Days	If less than one day
7	11	22	hr. min.

9. Birthplace Trinidad (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Sun Soy

13. Birthplace China

MOTHER 14. Maiden Name Dorothy Chow Juan

15. Birthplace Trinidad

16 (a) Informant Francis Chow Juan

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct 2 (month) (day) (year)

(c) Cemetery or crematory London Park

Location City

18 (a) Funeral director Uelrich Funeral Home

(b) Address 2235 Pleasant St Huntington, West Virginia

19 (a) OCT 2 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1948, at 5 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1948 to 10/1 1948, and that I last saw him alive on 10/1 1948.

Immediate cause of death: Brain Tumor — Duration: one year

Due to

Due to

Other Conditions CRANIO PHARYNGIOMA

(Include pregnancy within 3 months of death)

Date of operation Sept. 28 1948

Major findings of operation: Craniopharyngioma

of autopsy: Craniopharyngioma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Maurice L. Silver M.D.
Address Johns Hopkins Date signed 10/1/48

VS 159

667294

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 49a

Registered No. 667294

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: St. Joseph's HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town SPARROW'S POINT (If outside city or town limits, write RURAL and give town)
(d) Street No. BOX 60 ROUTE 10. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY OSTAPIUK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Separated.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 9, 18[illegible]

8. AGE: Years 56 Months 9 Days 21 If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Stanley Graczyk
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Helen Ostapiuk
(b) Address Box 60 Route 10 Sparrows Pt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 1007 Eastern Ave

19 (a) OCT 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30, 1948 at 2 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24, 1948 to Sept. 30, 1948. and that I last saw her alive on Sept. 30, 1948.

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to GENERALIZED CARCINOMATOSIS

Due to ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank W. Baker, Jr. M.D.
Address St. Joseph's Hospital Date signed 9-30-48

VS 150

667295

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92D

Registered No. 667295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk.Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 11 days
(e) Length of stay in Baltimore (yrs., mos., or days): 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: DC (b) County:
(c) City or town: Washington (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1007 - 4th St. NE (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country:

3 (a) FULL NAME: TONY DI MATTEO

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 578-01-7492

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Philomenia Di Matteo
6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): March 28, 1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
63	8	3		

9. Birthplace: Italy (Town, county, and state)
10. Usual Occupation: Tile setter
11. Industry or business:

MOTHER - FATHER
12. Name: Domenia Di Matteo
13. Birthplace: Italy

MOTHER
14. Maiden Name: Philomenia ?
15. Birthplace: Italy

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: Oct 2.48 (month) (day) (year)
(c) Cemetery or crematory: Washington D.C.
Location: Washington D.C.

18 (a) Funeral director: W.B. Chambers Co
(b) Address: Washington D.C.

19 (a) OCT 2 - 1948 (Date rec'd by Registrar) (b) Washington D.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1 1948 at 12:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1948 to Oct. 1 1948, and that I last saw him alive on Oct. 1 1948.

Immediate cause of death: Brucellosis — Duration: 2 Yrs.

Due to: Vegetative, stenosing, aortic valvulitis with cardiac hypertrophy

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon, M. D.
Address U.S. Marine Hospital, Balto. Signed 10/2/48

VS 150

667296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1062

667296 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1949 W. Mulberry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1949 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry G. Culp

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine Culp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1884

8. AGE: Years 63 | Months 11 | Days 20 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Con. Gas & Electric Co.

FATHER
12. Name Harry T. Culp
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Courts
15. Birthplace Md.

16 (a) Informant Mrs. Catherine Culp
(b) Address 1949 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4/48. (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2330 Frederick Rd.

18 (a) Funeral director Harry H. Pichtel
(b) Address 4101 Edmondson Ave.

19 (a) [illegible] Washington Blvd.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29/48 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 19 47 to 9-29-48 19
and that I last saw him alive on 9-29-48 19

Immediate cause of death Bronchiectasis — Duration 2yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature D. S. Shanahan M. D.
Address 1945 W. Baltimore St. Date signed 9-30-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

VS 150

G67297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9da

Registered No. G67297

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any wrong statement or omission should be carefully avoided.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2919 Edmondson Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2919 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Franklin Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-20-9799

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1948

8. AGE: Years 70 | Months 1 | Days 15 | If less than one day hr. min. 1878

9. Birthplace Lake Virginia (Town, county, and state)

10. Usual Occupation Mining Engineer

11. Industry or business Retired

FATHER
12. Name William Thompson
13. Birthplace Virginia

MOTHER
14. Maiden Name Frances Davis
15. Birthplace Virginia

16 (a) Informant Harry E. Thompson
(b) Address 3108 Gibbons Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2, 1948 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery
Location Balto Co. Md.

18 (a) Funeral director Lansing Byers
(b) Address 3005 Park Heights Ave

19 OCT 2 - 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1948 at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 19 to 9-29 1948 and that I last saw him alive on 9-29 1948

Immediate cause of death: Coronary occlusion — Duration: 36 hours
Due to: Hypertension — years
Due to: Arteriosclerosis — years
Due to:
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William L. Young M. D.
Address 3025 Belair Road Date signed 10-1-48

VS 180

67298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. 67298

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3713 N. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Mabor Hubin

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Thomas Mathew Hubin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5, 1909

8. AGE: Years	Months	Days	If less than one day
39	6	25	hr. min.

9. Birthplace Mississippi
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William T. France
13. Birthplace Md.

MOTHER
14. Maiden Name Etta E. Jones
15. Birthplace Md.

16 (a) Informant Mr. Thomas M. Hubin
(b) Address 3713 N. Rogers Ave.

17 (a) Burial (b) Date thereof 10/4/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum Gen.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md

19 (a) OCT 2 - 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30, 1948 at 8:22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Sept 1948 to 30 Sept 1948 and that I last saw h[illegible] alive on Sept 30 1948.

Immediate cause of death Peripheral vascular collapse & cardio-respiratory arrest.
Due to Rheumatic heart disease.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Tickner M.D.
Address West Baltimore Gen'l Hosp Date signed Sept 30 1948

VS 150

Penalty for wilfully making any false statement in this certificate is a fine of not more than $500 or imprisonment for not more than one year, or both. Please write plainly; use ink; do not abbreviate; be accurate, complete, and legible.

667299

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 828

667299
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 W. 34th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1743 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE MAY FICKE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife George Ficke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 25, 1873

8. AGE: Years	Months	Days	If less than one day
75	4	16	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Amos C. Wilson
13. Birthplace Rising Sun, Md.

MOTHER
14. Maiden Name Elizabeth Waterworth
15. Birthplace Baltimore, Md.

16. (a) Informant Mrs. Elizabeth Marsh
(b) Address 1743 Park Ave.

17 (a) Burial (b) Date thereof 10.4.48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 4 - 1948 (b) Timothy for Thomas [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1, 1948, at 6:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1948. to Oct 1 1948. and that I last saw her alive on Oct 1 1948.

Immediate cause of death
Cerebral thrombosis — Duration 4 da
Due to arteriosclerosis, generalized — 15 yr.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M.D.
Address 11 W. 29th ST Date signed Oct 2, 1948

VS 150

667300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

461

Registered No. 667300

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1136 Harford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1136 Harford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Bernard Aul

3 (b) If veteran, name war: No
3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife: no
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1880

8. AGE: Years	Months	Days	If less than one day
67	11	24	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation City Employee
11. Industry or business Balto. City Dept.

FATHER
12. Name John Aul
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary E.
15. Birthplace Germany

16 (a) Informant Miss Catherine A. Crosbie
(b) Address 1136 Harford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location 4430 Belair Rd

18 (a) Funeral director Elsner W. Conklin
(b) Address 924 E. Eager St

19 (a) OCT 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30, 1948 at 3 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to Sept 30 1948, and that I last saw him alive on Sept 28 1948

Immediate cause of death: Carcinoma of Stomach — Duration: 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William E. Pearce M. D.
Address 1105 N. Charles St Date signed Oct 1, 48

V S 150

G67301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95R

G67301

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street [redacted]
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Sparks (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME BELLE Edna JACKSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	negro	married

6 (b) Name of husband or wife Cornelius Jackson

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Sept 30. 1896

8. AGE: Years	Months	Days	If less than one day
52	—	12	hr. min.

9. Birthplace Moubtown, Balto Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George H. Harris
13. Birthplace Mt Fubston, Md.

MOTHER
14. Maiden Name Elizabeth Asbith
15 Birthplace Virginia

16 (a) Informant Mrs Cornelius Jackson
(b) Address Sparks, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 4-48 (month) (day) (year)
(c) Cemetery or crematory St Lukes A.M.E.
Location Sparks, Md.

18 (a) Funeral director W. Brooks
(b) Address Sparks, Md.

1948 OCT 3 — (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2-48 19 . at 6 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23-48 19 , to 10-2-48 19 , and that I last saw her alive on 10-2-48 19 .

Immediate cause of death Coronary Thrombosis

Due to Subacute bacterial endocarditis

Due to Rheumatic Heart disease

Other Conditions Calculus - left ag, possible cirrhosis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Subacute Bacterial Endocarditis Numerous emboli

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Roberts M. D.

Address West. 1859. Date signed 10-2-48

VS 150

667302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

667302
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 orleans St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emmett Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Henry Harris
13. Birthplace Va

MOTHER 14. Maiden Name Ann Harris
15. Birthplace Va

16 (a) Informant Mrs Clifton Harris
(b) Address 1618 E. Eager St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 3-48 (month) (day) (year)
(c) Cemetery or crematory Memorial Cem.
Location Petersburg Va

18 (a) Funeral director Troy O. Wilson
(b) Address 1000 Brantley ave

OCT 3 - 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~Sept~~ Oct 1 1948, at 2.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1948, to Oct 1 1948, and that I last saw h im alive on Sept 15 1948.

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerosis (Coronary) 1 yr.

Due to Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. E. Burwell
Address 171 Aisquith St Date signed 10-2-48 M D

VS 150

G67303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G67303 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2131 W. Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2131 W. Baltimore St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Leven Wooters

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 214-16-6623

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Separated
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 3, 1904

8. AGE: Years 44 | Months 7 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Daniel Leven Wooters
13. Birthplace Maryland

MOTHER
14. Maiden Name Rose Walters
15. Birthplace Maryland

16 (a) Informant Laura Irene Wright
(b) Address 2131 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore, National Location Baltimore, Maryland

18 (a) Funeral director George L. Schwabe
(b) Address 2104 Frederick Avenue Pimlico Station Baltimore, Md.

OCT 3 1948 (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1948 at 8:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1948 to 10/1 1948 and that I last saw him alive on 10/1 1948

Immediate cause of death: Carcinoma of Lung (Int) — Duration: 4 mos

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 8/1/48
Major findings of operation: Carcinoma of at lung
of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 2030 Wilkens Ave Date signed 10/2/48

VS 150

667504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127a

Registered No. 667504

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Finksburg Rt #1
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Carroll Haines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Oct 14 1875

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72	11	18		

9. Birthplace CARROLL COUNTY Maryland (Town, county, and state)
10. Usual Occupation Carpenter retired
11. Industry or business

FATHER
12. Name Abraham Haines
13. Birthplace MARYLAND

MOTHER
14. Maiden Name Margaret Eckman
15. Birthplace MARYLAND

16 (a) Informant Mary E. Haines
(b) Address Finksburg Rt #1 Md

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT 5 1948 (month) (day) (year)
(c) Cemetery or crematory MT PLEASANT CEM.
Location GAMBER, MD.

18 (a) Funeral director JOHN R. BYERS
(b) Address WESTMINSTER, MD.

19 (a) OCT 3 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 2 1948 at 6:00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-21 1948 to 10-2 1948 and that I last saw him alive on 10-2 1948

Immediate cause of death: Cardio-resp failure — Duration: 3-4 wks
Due to: post-operative transurethral resection
Due to: also general vascular disease.
Other Conditions: Benign prostatic hypertrophy
(Including pregnancy within 3 months of death)
Date of operation 10-1-48
Major findings of operation: Benign prostatic hypertrophy
of autopsy: not granted

PHYSICIAN (Underline the one to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard E. Martin M.D.
Address Maryland Gen. Hosp. Date signed 10-2-48

VS 193

G67305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. G67305

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2816 N. Calvert St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME John S. Corcoran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1865

8. AGE: Years 83 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Frank Corcoran

13. Birthplace Aboard Ship, U.S. Water

MOTHER 14. Maiden Name Rebecca Sheppard

15 Birthplace Maryland

16 (a) Informant Hosp. Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ New Cathedral

Location Baltimore, Md.

18 (a) Funeral director H. H. Mister & Son

(b) Address 90 [illegible] Baltimore, Md.

OCT 3 1948 (Date received) (b) Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1948 at 9:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1948 to Oct 2 1948 and that I last saw him alive on Oct 2 1948.

Immediate cause of death Pneumonia — Duration

Due to

Due to

Other Conditions Art. sclerosis
Art. sclerotic heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify home, farm, industrial place, etc.)

(e) Means of injury

23. Signature C. Sturnsla

Address Mercy Hosp. Date signed 10/2/48 M.D.

1092

VS 199

667306

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

927

Registered No. 667306

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3313 Norfolk Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Louis Cohen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Mary Cohen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years: 59 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Jacob ~~Hyman~~
13. Birthplace: Russia

MOTHER
14. Maiden Name: ~~Sophie Hyman~~
15. Birthplace: Russia

16 (a) Informant: Mary Cohen
(b) Address: 3313 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-48 (month) (day) (year)
(c) Cemetery or crematory: Beth Tfiloh
Location: Windsor Mill Road

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2104 Eutaw Place, Balto, Md.

OCT 4 1948
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1948 at 8:26 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2, 1948 to Oct. 3, 1948 and that I last saw h[illegible] alive on Oct. 3, 1948

Immediate cause of death: Coronary Occlusion — Duration: 24 hr.

Due to: Arteriosclerotic Heart Disease — Duration: yrs.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature John R. Smith Jr. M.D.
Address Union Memorial Hosp. Date signed 10/5/48

VS 139

667307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

121B

Registered No. 667307

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 No. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Schuster

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	M

6 (b) Name of husband or wife Max
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
45				

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Abraham Kamerow
13. Birthplace Russia

MOTHER
14. Maiden Name Mollie
15. Birthplace Russia

16 (a) Informant Max Schuster
(b) Address 2014 N Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 206 Eutaw Place

OCT 3 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1948, at 1:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/28 1948 to 10/1 1948, and that I last saw her alive on 10/1 1948.

Immediate cause of death Pulmonary Edema — Duration

Due to Hypertensive Ht Disease Arteriosclerotic Ht. Disease

Due to Chronic Glomerulonephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marjorie Dreman M.D. M. D.
Address Sinai Hosp Baltimore Md Date signed 10/1/48

VS 150

667308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667308 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hours
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Sykesville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM HEPNER

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-16-7261

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Evelyn Ely

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13 1882

8. AGE: Years 66 | Months 0 | Days 19 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Bank

FATHER 12. Name Asa Hepner

13. Birthplace Md

MOTHER 14. Maiden Name Hettie Warfield

15. Birthplace Md

16 (a) Informant Mrs Evelyn Hepner

(b) Address Sykesville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/48 (month) (day) (year)

(c) Cemetery or crematory Springfield

Location Sykesville, Md

18 (a) Funeral director C. Harry Weer

(b) Address Sykesville, Md.

19 (a) Huntington Williamsport (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1948 at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1948 to Oct 2 1948, and that I last saw h[im] alive on Oct 2 1948.

Immediate cause of death	Duration
Cardiac Arrest	
Due to Coronary infarction	3
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Shaer

Address Univ Hospital Date signed 10/2/48

VS 150

Instructions for preparation of death certificate and legibly.

G67309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 E

Registered No. G67309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Good Samaritan, Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 E. Oliver St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALMIRA NORRIS

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: James F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1875

8. AGE: Years	Months	Days	If less than one day
73	4	10	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John R. Scroggs
13. Birthplace Md

MOTHER
14. Maiden Name Almira Hart
15. Birthplace Md

16 (a) Informant Edith Collins
(b) Address 1621 E. Cliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Crematory Parkwood
rkville, Md.

18 (a) Undertaker or William Cook, Inc
(b) Address 1217 St. Paul St.

OCT 8 1948 (Date received by Registrar) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1948 at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1948 to Sept 30 1948 and that I last saw h[illegible] alive on Sept 30 1948.

Immediate cause of death	Duration
Cerebral Arteriosclerosis	Unknown
Due to Thrombocytic Purpura	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify (yes) or (no))
(e) Means of injury

23. Signature Helen Ellison
Address 1621 E. Oliver St. Date signed 10/4/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667320

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 N. Charles St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Medford B. Mann

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-22-2005

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Rena P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 28, 1890

8. AGE: Years 57 | Months 3 | Days 4 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Chief Engineer

11. Industry or business

FATHER
12. Name Thomas Mann
13. Birthplace Md.

MOTHER
14. Maiden Name Mary B. Wilmer
15. Birthplace Md

16 (a) Informant Mrs Rena P. Mann
(b) Address 2011 N. Charles St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

(Date rec'd by registrar) Oct 8 1948 (b) Huntington Williamson M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2 1948 at 10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/2 1948 to 10/2 1948 and that I last saw him alive on 10/2 1948.

Immediate cause of death: Respiratory failure — Duration
Due to Cerebro vascular accident
Due to Hypertension, severe
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles J. Klauber M. D.
Address Maryland General Date signed 10/2/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667311 ✓ 667311 Registered No. 121a

667311

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 N. Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Clyde Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-18-5721

4 Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July - 11 - 1870

8. AGE: Years 78 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Cameron Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Mrs Nellie Shaffer

(b) Address 222 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd

18 (a) Funeral director John E. O'Malley Inc

(b) Address 2436 E. Oliver St

19 (Date received by registrar) 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 2 1948 at 10.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 30 1948, to OCT 2 1948, and that I last saw h(im) alive on OCT 2 1948.

Immediate cause of death CORONARY THROMBOSIS — Duration 2 DAYS.

Due to HYPERTENSIVE CARDIO-VASCULAR RENAL DISEASE —

Due to

Other Conditions MYOCARDITIS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature James F Kavanagh M.D. M. D.

Address 30 W McElderry St Date signed 10-2-48

VS 150

G67312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G673127

Registered No. 927

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light Street

(c) Hospital or institution: South Baltimore Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 26 (If outside city or town limits, write RURAL and give town)

(d) Street No. 3906 Fairhaven Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME CECILIA H. WHITAKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clinton H. Whitaker

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) 9-12-1886

8. AGE: Years 62 Months Days 18 If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Dawson

13. Birthplace Cecil Co. Md.

MOTHER 14. Maiden Name Mary Ann Edwards

15. Birthplace Georgetown Ward Del.

16 (a) Informant Clinton H. Whitaker

(b) Address 3906 Fairhaven Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-4-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director John C. Miller Inc

(b) Address 2434 E. Oliver St

OCT 6 - 1948 (Date rec'd by registrar) (b) Funeration Permit No. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30 1948, at 6 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-28 1948, to 9-30 1948, and that I last saw her alive on 9-30 1948.

Immediate cause of death: Pulmonary Edema — Duration: 1 day

Due to Cardiac Failure — 2 days

Due to Coronary Occlusion — 3 days

Due to Arteriosclerotic CV Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward A. Kaufman M.D.

Address 1213 Light St. Date signed 9-29-48

VS 150

667313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49c

667313 Registered No.

Type or print with pen and ink: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Overlea (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Leslie Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Esther Antonette Paul

3 (b) If veteran, name war

3 (c) Social Security Account No. 258-05-4994

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James T. Paul 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 12 1917

8. AGE: Years	Months	Days	If less than one day
31			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name David Strickland
13. Birthplace Va.

MOTHER
14. Maiden Name Ewala MacMillan
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Frederick Smith, Inc
(b) Address 3014 E. Monument St

BCI 3-1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1 19[illegible], at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6 19[illegible] to 10-1 19[illegible], and that I last saw her alive on 10/1 19[illegible].

Immediate cause of death: Gastro-Intestinal Hemorrhage, Massive — Duration

Due to: Carcinoma Bartholins Gland with metastases to — 10 mos

Due to: Abdominal Viscera, Retroperitoneal structures

Other Conditions: Gastro-Intestinal Hemorrhage (Include pregnancy within 3 months of death)

Date of operation Dec. 12, 1947

Major findings of operation: Carcinoma Bartholins Gland with Metastases

of autopsy: As Above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Vincent Hanson, M.D. M.D.
Address Johns Hopkins Hosp Date signed 10/1/48

VS 150

667514

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

667514 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 S Clinton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 S Clinton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 10 1878

8. AGE: Years 70 | Months 8 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name James Hadaway
13. Birthplace Md

MOTHER
14. Maiden Name Priscilla Sinclair
15. Birthplace Md

16 (a) Informant Miss Lillian Thomas
(b) Address 3306 E Lombard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilbur Funeral Home
(b) Address 200 E Orleans St

19 (a) 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1948 at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to Oct 1 1948
and that I last saw her alive on Oct 1 1948

Immediate cause of death Arteriosclerotic cardiovascular disease — Duration

Due to Arteriosclerosis

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John J Gould M. D.
Address 147 East Ave Date signed 10-2-48

VS 150

93D

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The accuracy of this certificate is extremely important

CERTIFICATE CORRECTED 9-1-50 67315

To be CKed by Medical [illegible] CITY HEALTH DEPARTMENT Registered No.

CERTIFICATE OF DEATH

67315 Case 123403

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 St. Paul Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Duffy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Della Duffy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? ? ?

8. AGE: Years 76 | Months | Days | If less than one day: hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hosp. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

OCT 3 - 1948 (Date rec'd by reg.) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/1 19 48 at 1:00 AM (1325) Hrs.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 19 48 to 10/1 19 48.
and that I last saw him alive on 10/1/ 19 48.

Immediate cause of death: Pulmonary edema — Duration: 2 days
Due to Arteriosclerotic Heart Disease — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Vickers M.D.
Address Balto City Hosp Date signed 3 Oct 48

CERTIFICATION APPROVED BY

CHIEF OR ASST. MEDICAL EXAMINER

VS 150

667316 ✓ 667316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1407 William St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 William St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Ann Petty

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 22- 1872
8. AGE: Years 76 | Months — | Days 8 | If less than one day hr. min.
9. Birthplace Baltimore. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James T. Petty
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Gallagher
15. Birthplace Ireland

16 (a) Informant John A. Gallagher
(b) Address 1407 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 - 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1948 to Sept 30 1948 and that I last saw h[illegible] alive on Sept 30 1948.

Immediate cause of death.	Duration
Chronic Endocarditis	6 mos
Due to Pulmonary Oedema	2 hrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. B. Wheeler M. D.
Address 279 Williams St Date signed 10/12/48

VS 180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667317

667317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME Sallie Hopkins Gray
3 (b) If veteran, name war —
3 (c) Social Security account No. —

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced widowed
6 (b) Name of husband or wife Dead Wells Gray
6 (c) If alive, give age — years
7. Birth date of deceased mo. November day 12 yr 1863 (or unknown)
8. AGE: Years 64? Months 10 Days 18 If less than one day hr — min —
9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Wade Hopkins (or unknown)
13. Birthplace South Carolina

MOTHER
14. Maiden Name Sophie Walton (or unknown)
15. Birthplace South Carolina

16 (a) Informant Sarah Nunis
(b) Address 1222 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 3, 1948 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location —

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3237 Lafayette St. Huntington Pittsburgh, Pa.

19 (a) OCT 4 - 1948 (Date rec'd by registrar) (b) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30/48 1948 at 5:30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/26 1948 to 9/30/48 and that I last saw him alive on 9/30/48

Immediate cause of death Pericardial Tamponade due to Dissecting aneurysm of Abdominal Aorta

Duration approximately 3 weeks

Due to generalized Arteriosclerosis

Due to Pulmonary Edema and congestion

Other Conditions Caloric Passive Congestion of Liver & Spleen

(Including pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature S. E. Grady, JR M.D.
Address — Date signed —

VS 150

673518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 673518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 N. Pine Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROY FLETCHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife ROSE BEAM

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 2 1948 (illegible)

8. AGE: Years 39 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace NORTH CAROLINA (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name WILLIAM FLETCHER
13. Birthplace FORSYTHE CO. N. CAROLINA

MOTHER
14. Maiden Name PERMILA COBBLER
15. Birthplace FORSYTHE CO, N. CAROLINA

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 10/3/48 (month)

(c) Cemetery or crematory WINSTON SALEM N. C.
Location

18 (a) Funeral director WM. J. TICKNER SONS
(b) Address NORTH & PENNSYLVANIA AVES.

19 (a) OCT 4 - 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 19 48, at 1:40 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐, and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Rupture of liver, Hemorrhage, fractures of ribs, rt.

Due to

Other Conditions: Contusions & lacerations of R. side of head

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following.

(a) Date of injury 10-1-48 at 11:20 P M.

(b) Where did injury occur? Route #1, Dorsey, Md.

(c) Did injury occur at home, on farm, in industrial place, in public place? public While at work? no

(d) Means of injury? pedestrian struck by auto

23. Signature Earl K. Royer M.D.
Medical Examiner.

Date signed 10-2-48

Type or print plainly with indelible pencil. Physicians: please write the causes of death clearly and legibly.

667319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667319 Registered No.

49a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Kent
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. Rock Hall md (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Davis.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 7 - 1909

8. AGE: Years 39 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER
12. Name Carroll.
13. Birthplace Md

MOTHER
14. Maiden Name Mary Cater.
15. Birthplace Md

16 (a) Informant James Davis
(b) Address Rock Hall Ed. 3381

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Wesley Chapel
Location Rock Hall Md

18 (a) Funeral director Edgar L. Lane
(b) Address Church Hill, Md

19 (a) OCT 4 - 1948 (Date rec'd by registrar) (b) Huntingtown Maryland Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1948 at 12 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/29 1948 to 10/3 1948, and that I last saw h- alive on 10/3 1948

Immediate cause of death	Duration
CARDIO - RESPIRATORY FAILURE	
Due to PULMONARY EMBOLISM	
Due to BILATERAL OVARIAN CARCINOMA & GENERALIZED	
Other Conditions ABDOMINAL METASTASIS	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B. Shaw M. D.
Address St Agnes Hosp Date signed 10/4/48

667320

AB-123251

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46F

Registered No. 667320

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Light St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Eugene Jeffries~~ EUGENE JEFFERIES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	? SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) ?-?-? 1868

8. AGE: Years	Months	Days	If less than one day
83?			hr. min.

9. Birthplace ? BALTIMORE, MD (Town, county, and state)
10. Usual Occupation ? EMPLOYEE OF
11. Industry or business CITY OF BALTIMORE

FATHER
12. Name ? JOHN J. JEFFERIES
13. Birthplace ? BALTIMORE, MD.

MOTHER
14. Maiden Name ? ELIZABETH SCHAEFFER
15. Birthplace ? BALTIMORE, MD

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK
Location FREDERICK RD

18 (a) Funeral director JOHN F. DOWNS, INC.
(b) Address 715 LIGHT ST -30

19 OCT 4 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 19 48 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24- 19 48 to 9-30- 19 48, and that I last saw him alive on 9-30- 1948

Immediate cause of death Carcinoma of bile ducts — Duration 1-2 yr ?

Due to

Due to

Other Conditions HAC vs C failure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: on abdo

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. T. Welsh
Address B C H Date signed 10-1-48

VS 159

G667321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667321

Type or print clearly in black ink. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2852 HARFORD RD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country —

3 (a) FULL NAME MRS. EMILY D. EVANS (EMILY DIVER EVANS)

3 (b) If veteran, name war NO

3 (c) Social Security Account No. NO

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: RALPH EVANS

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): FEB 14, 1890

8. AGE: Years: 58 | Months: 7 | Days: 16 | If less than one day: ____ hr. ____ min.

9. Birthplace: BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation: HOUSEWIFE

11. Industry or business: —

FATHER
12. Name: WILLIAM DIVER
13. Birthplace: MARYLAND

MOTHER
14. Maiden Name: MARY
15. Birthplace: MARYLAND

16 (a) Informant: HUSBAND
(b) Address: SAME AS DECEASED

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)
(c) ~~Cemetery~~ or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 OCT 4 - 1948 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 SEPT 1948 at 7 15 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 28 SEPT 1948 to 30 SEPT 1948. and that I last saw her alive on 30 SEPT 1948.

Immediate cause of death: CARDIO RESPIRATORY FAILURE — Duration: 4 HOURS
Due to: CEREBRAL HEMORRHAGE — Duration: 2½ DAYS
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)

Date of operation: NONE
Major findings of operation: —
of autopsy: REFUSED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature: Donald L. England M D
Address: MARYLAND GEN HOSP. Date signed: 30 SEPT 48

VS 159

B.C.C 19440

667322

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667322 Registered No. 1940

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 East Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Ishel Bush (Leroy Josiah Bush)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1945

8. AGE: Years 3 | Months 7 | Days 12 | If less than one day hr. min.

9 Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Rayfield Bush
13. Birthplace Dallas, Texas

MOTHER
14. Maiden Name Martha Griggs
15. Birthplace Georgia

16 (a) Informant Rayfield Bush
(b) Address 1627 E. Preston St.

17 (a) Burial (b) Date of burial Oct 4 1948
(Burial, cremation, or removal) (month)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert L. Young
(b) Address 1[illegible] Pennsylvania Ave.

19 (a) OCT 4 - 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1948, at 4.03 P.M.

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Fractured femur
Due to
Other Conditions Multiple wounds on head - burns.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-1-48 at approx. 3.45 P. M.
(b) Where did injury occur? Preston St. & Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? No
(d) Means of injury pedestrian struck by truck

23. Signature Howard J. Mulders M.D.
Medical Examiner
Date signed October 2, 1948

VS 151

667323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

Registered No. 667323

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 W. Fayette St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mr Frank Wiesner Wisniewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 210093250

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1912

8. AGE: Years	Months	Days	If less than one day
36	3		hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Florist

11. Industry or business

FATHER
12. Name Stanislaw
13. Birthplace Poland

MOTHER
14. Maiden Name Veronica Kopsowski
15. Birthplace Poland

16 (a) Informant Bernard Wiesner
(b) Address 315 S. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozazgenski
(b) Address 1930 Eastern Ave

19 (a) OCT 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2-48 19 . at 3:14 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29-48 19 . to 10-2 1948, and that I last saw h im alive on 10-2-48 19 .

Immediate cause of death	Duration
Respiratory failure -	
Due to Haemorrhage	
Due to Oesophageal Varices	
Due to Portal Cerrhosis	
Other Conditions Due to chronic alcoholism	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Hahn M.D.
Address University Hosp Date signed 10-2-48 M. D.

G673324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 R

G673324 Registered No.

Please write plainly. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 134 S. Bethel St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2y
(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 134 S. Bethel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Regina Washington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1908

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Driver
11. Industry or business

FATHER
12. Name Leonard Washington
13. Birthplace St Marys Co. Md

MOTHER
14. Maiden Name Alice Cannon
15. Birthplace Wilmington, Del.

16 (a) Informant Regina Washington
(b) Address 134 S. Bethel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1110 Blanton St

19 Oct 4 1948 (Date rec'd by Registrar) Huntington Hallowell, Me Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1948, at 1145 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1948 to Sept 30 1948, and that I last saw h[illegible] alive on Sept 30 1948.

Immediate cause of death Acute Pulmonary tuberculosis — Duration 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. E. Bennett M. D.
Address 171 Asquith St Date signed 10-2-48

VS 150

67352 Bal 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 120a

Registered No. 67325

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town 1616 Harlem Ave. Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. ..... (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3 (a) FULL NAME Goldie Towell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 8-29-79

8. AGE: Years	Months	Days	If less than one day
69	1	3	hr. ..... min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Miles Towell
13. Birthplace N.C.

MOTHER
14. Maiden Name Amanda ?
15. Birthplace N.C.

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2, 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Md.
18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley Ave Huntington Woodlawn, Md.
19 (a) OCT 4 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1 1948, at 9:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1948 to 10-1 1948, and that I last saw him alive on 10-1 1948.

Immediate cause of death peripheral vascular collapse — Duration .....
Due to gastro-enteric dilatation .....
Due to Recurrent enteritis .....
Other Conditions Renal insufficiency uremia .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury .....

23. Signature William O. Winternitz M.D.
Address Johns Hopkins Hospital Signed 10-2-48

VS 190

667326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667326

15-1139 121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 203 N. Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Banks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col.	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-08

8. AGE: Years	Months	Days	If less than one day
40	8	-	hr. min.

9. Birthplace Va (Town, county and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Joe Venable
13. Birthplace Va.

MOTHER
14. Maiden Name Ann Thorn
15. Birthplace Va.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calv. Cem
Location Brooklyn Md
18 (a) Funeral director Chas O. Wilson
(b) Address 1000 Brantley Ave
19 (a) Oct 4 - 1948 (b) Huntingtown Prince Georges Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1948 at 12 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16- 1948 to 10-2- 1948.
and that I last saw h[illegible] alive on 10-2- 1948.

	Duration
Immediate cause of death Subphrenic abscess and Empyema thoracis	10 (?)
Due to Generalized peritonitis	14
Due to Perforated Appendix	21 (?)
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation September 17, 1948
Major findings of operation: Appendiceal abscess; generalized peritonitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury
23. Signature David C. Sassion, Jr. M.D.
Address John Hopkins Hosp Date signed 10/3/48

VS 150

G673327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G673327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 837 N. Central Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 837 N. Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bradbery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C.	Widow

6 (b) Name of husband or wife Edward (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 2, 1890

8. AGE: Years	Months	Days	If less than one day
58	6	29	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ?
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace Va.

16 (a) Informant Eleanor Mc Nutt
(b) Address 837 N. Central Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location A.A. County, Md.

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 1364 N. Central Ave

19 (a) OCT 4 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1 1948, at 3:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14/ 1948, to 10/1 1948, and that I last saw her alive on 10/1 1948.

Immediate cause of death Bronchopneumonia

Due to Myocarditis

Due to

Other Conditions Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 4 W

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert L. Lapford MD
Address 837 N. Central St Date signed 10/4/48

VS 153

BC-48-00012 ✓ 667328

667328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

Registered No. 667328

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 N. Carrollton Aves (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

✓

3 (a) FULL NAME Jerald Keys

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 2, 1948.

8. AGE: Years — | Months 8 | Days — | If less than one day hr. min.

9. Birthplace Baltimore, Md.. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Leroy Keys.

FATHER 13. Birthplace Philadelphia, Penna.

MOTHER 14. Maiden Name Inez Brown.

MOTHER 15 Birthplace Sumter, S. C.

16 (a) Informant Inez Keys.

(b) Address 109 N. Carrollton Aves.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2 1948 (month) (day) (year)

(c) Cemetery or crematory M.T. Auburn Cem

Location

18 (a) Funeral director Thos. Kater R. Williams

(b) Address 322 N. Charles St

19 OCT 4 - 1948 (Date rec'd by Registrar) (b) Huntingdon for Williams, Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30 1948 at 11 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1948 to 9-30 1948. and that I last saw h/m alive on 9-30 1948.

Immediate cause of death Respiratory failure

Due to Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
several

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Hredrick Jr. M. D.

Address Univ. Hosp. Date signed 10-1-48

VS 150

X

G57523

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. G57523

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 3104 Foster Avenue
(c) Hospital or institution:
S
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3104 Foster Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN KRASKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Elizabeth Kraska

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 13 1891

8. AGE: Years 57 | Months 8 | Days 20 | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: ?
13. Birthplace

MOTHER
14. Maiden Name: ?
15. Birthplace

16 (a) Informant: George Kraska
(b) Address: 3104 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 6 1948 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart
Location: German Hill Rd

18 (a) Funeral director: John J. Duda
(b) Address: 2669 Hudson St

19 (a) OCT 4 - 1948 (Date rec'd by registrar) Washington Holliams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1948, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic CV disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Subinski M.D. Medical Examiner.
Date signed 10-2-48

VS 151

667330

667330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — D. 21.
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 153 Bradley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MASSCELINE Marceline Savage

Carpenter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex C | 5. Color or race F | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1902

8. AGE: Years 46 | Months 5 | Days 11 | If less than one day hr. min.

D.J.M.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Peter Savage
13. Birthplace Virginia

MOTHER
14. Maiden Name Mildred ?
15. Birthplace 933 Shilds Place

16 (a) Informant Henry Carpenter
(b) Address 933 Shilds Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (mo.) (day) (yr.)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director A.A. HALSTEAD
(b) Address 918 Druid Hill Avenue

19 (a) OCT 4 - 1948 (Date rec'd by registrar) Huntington Williams, Mgr. REGISTRAR

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2 1948 at 1.25 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocarditis
Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Schmidt M.D.
Medical Examiner.
Date signed 10/3/48

VS 151

673331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G673531

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 E. 23rd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 E. 23rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CLARISSA MAY MUTH

3 (b) If veteran, name war: --

3 (c) Social Security Account No.:

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 23, 1896

8. AGE: Years: 52 Months: 4 Days: 9 If less than one day: hr. min

9. Birthplace: Sparks, Md. (Balto. Co.) (Town, county, and state)

10. Usual Occupation: School Teacher

11. Industry or business:

FATHER
12. Name: George R. Muth
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Sarah R. Tracey
15. Birthplace: Baltimore

16 (a) Informant: Mrs. Esther E. Hamel
(b) Address: 5109 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/48 (month) (day) (year)
(c) Cemetery or crematory: Bosley's Cem.
Location: Sparks, Md.

18 (a) Funeral director: WILLIAM J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 4 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1948, at 7:04 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from June 1 1948, to Oct 2 1948, and that I last saw her alive on Sept 30 1948.

Immediate cause of death: Coronary Thrombosis

Duration: four months

Due to: Myocardial Weakness

Duration: 5-6 yrs.

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Ellsworth Polk, M.D.
Address 2431 Maryland Ave Balto 18, Md. Date signed Oct 4 48

Physicians: please write the causes of death clearly and legibly.

67332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 67332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 E 27th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 E. 27th St; (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia Ann Adams

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex 2 | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John J Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/19/1889

8. AGE: Years 59 | Months 9 | Days 13 | If less than one day: hr. min.

9. Birthplace Balto Co. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Matthew Walsh
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Kennedy
15. Birthplace Ireland

16 (a) Informant Mr John J Adams
(b) Address 313 E 27th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Forest Park

18 (a) Funeral director J. J. Fagan & Sons
(b) Address 1618 Light St

19 OCT 4 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2/48 (month) (day) (year) at 1A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/1/48 to 10/2/48 and that I last saw her alive on 10/2/48

Immediate cause of death: cerebral hemorrhage — Duration

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm B Seale M.D.
Address 517 Medical Arts Date signed 10/3/48

VS 50

67333

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 67333

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Dot
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. Apt #166 Northwood Apts (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Vernon Caneva

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-09-9764

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Gladys Caneva

6 (c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): Oct. 9 - 1904

8. AGE: Years: 43 | Months: 11 | Days: 23 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Factory Superintendent

11. Industry or business: U.S. Printing & Lithograph

FATHER
12. Name: Clarence Caneva
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Marie Ross
15. Birthplace: Germany

16 (a) Informant: Mrs. Gladys Caneva
(b) Address: #319 Markle Hall Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4/48 (month, day, year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Rd.

18 (a) Funeral director: Krause Funeral Home
(b) Address: 1216 E. Chase St. Baltimore, Md.

19 (a) OCT 4 1948 (b) Registrar
(Corrected by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1 1948, at 10:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at: M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: C. P. Tulenko M.D. (Medical Examiner.)
Date signed: 10/1/48

VS 151

G67334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G67334 Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles St.
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 320 N. Monroe St. Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Sulka

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-8731

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Married

6 (b) Name of husband or wife Anna Sulka
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 28 -1888

8. AGE: Years	Months	Days	If less than one day
60 Yrs.	6	5	hr. min.

9. Birthplace Czechoslovakia --Brunn (Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business Albert F. Goetze Co.

FATHER
12. Name James Sulka
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Unknown
15. Birthplace Czechoslovakia

16 (a) Informant Anna Sulka (wife)
(b) Address 320 N. Monroe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5/48 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore Maryland

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 EUTAW PLACE..17

19 (a) OCT 4 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1948 at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1940 to Oct 2, 1948
and that I last saw h alive on Oct 2 1948

Immediate cause of death Acute Pulmonary Edema. — Duration 1 day

Due to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Dyson M.D.
Address 876 Wilkens Ave Date signed 10/2/48

VS 159

667335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 667335

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4019 8d ST
(c) Hospital or institution:

25+

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4019 8d ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD H. BEEFELT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6. (b) Name of ~~husband or~~ wife Late BARBARA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 26 1871

8. AGE: Years	Months	Days	If less than one day
77	2	7	hr. min.

9. Birthplace MARYLAND
(Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name EDWARD D
13. Birthplace MD.

MOTHER
14. Maiden Name ROSE —
15. Birthplace MD.

16 (a) Informant MRS CARRIE DAVIS
(b) Address 4019 8d ST

17 (a) BURIAL (b) Date thereof OCT 6 '48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location EDMONDSON AVE + LONGWOOD

18 (a) Funeral director Henry A Wolfe
(b) Address 4101 Edmondson Ave Huntington Hollins 4600

19 (a) OCT 4 1948 (Date received by Registrar)
D.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 3 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1948 to Oct 3 1948.
and that I last saw him alive on Oct 2 1948.

Immediate cause of death	Duration
cerebral hemorrhage	
Due to hypertensive cardio	
Due to vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip W. Kreuter M.D.
Address 302 Latrobe Date signed 10/4/48

Philip W. Kreuter

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G673336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G673336

Leh 122408

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2934 Greenmount Avenue 18 (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME George Beldovitz ALSO Name As (George A Belle)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/18/10

8. AGE: Years 38 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George
13. Birthplace Europe

MOTHER
14. Maiden Name Anna Kawaski
15. Birthplace Md.

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 10/5/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer.
Location Balto Md

18 (a) Funeral director C. Vernon Lemmon
(b) Address 461 Park Heights Huntington Williams, Md

19 OCT 4 - 1948 (Date rec'd by Registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1948 at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25/48 to 10/1/48.
and that I last saw him alive on 10/1/48

Immediate cause of death

Due to Pulm + be

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration: ? yrs.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Gayle Burton, M.D.
Address Baltimore City Hospitals Date signed 10/4/48

VS 150

G67337

AB-119565

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 1/10a

G67337 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Druery

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary (nee Holston)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 8- 1910

8. AGE: Years	Months	Days	If less than one day
~~39~~ 38	1		hr. min.

9. Birthplace Md. Baltimore, Md.
(Town, county, and state)
10. Usual Occupation ?
11. Industry or business Crown Cork & Seal Co.,

FATHER
12. Name Otto Druery (D
13. Birthplace Md.

MOTHER
14. Maiden Name Bertha Gould (D
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) OCT 4 - 1948 (Date rec'd by registrar) Huntington Woods, Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30- 1948 at 8.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9- 1948 to 9-30- 1948, and that I last saw h im alive on 9-30- 1948

Immediate cause of death Bronchopneumonia
Bronchiectasis, bilateral
Purulent empyema on rt.
Due to Clinical Evidence
amyloidosis.
Due to
Other Conditions Old tuberculosis
? active
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: same

Duration ? years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David M. Marine M. D.
Address 4940 Eastern Ave Date signed 10-2-48

VS 150

Please write the causes of death clearly and legibly. Physicians: Especially important. Please certify supplied. Use

667338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667338

667338

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any false statement or omission of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5203 Cuthbert Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME PETER E. WERTZ

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-2669

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Barbara Wertz

6 (c) If alive, give age 9 years

7. Birth date of deceased (mo., day, yr.) June 21 1880

8. AGE: Years 68 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Alsace Md (Town, county and state)

10. Usual Occupation Retired Route Driver

11. Industry or business Rice Bakery

FATHER 12. Name John Wertz

13. Birthplace Carroll Co Md

MOTHER 14. Maiden Name — Hoffacker

15. Birthplace Carroll Co Md

16 (a) Informant Donald E Wertz

(b) Address 5268 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6 1948 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director Harry H Armacost

(b) Address 1918 Reisterstown Road

19 (a) OCT 4 - 1948 (Date rec'd by registrar) (b) Huntington Valley, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1948 at 5 40 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/2 1948 to 10/3 1948 and that I last saw h in alive on 10/3 1948.

Immediate cause of death Cerebral Thrombosis

Due to Embolization from Fibrillating Auricle

Due to Arteriosclerotic & Hypertensive Heart Disease

Other Conditions Splenic Infarct

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above -

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard Epstein M.D.

Address Sinai Hospital Date signed 10/3/48

VS 150

G67339 ✓ G67339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½
(e) Length of stay in Baltimore (yrs., mos., or days) 58y 8m 9d

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 GORSUCH AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME ANNIE EDNA KING (Anna Eva King)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Stephen Leo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) JAN. 23, 1890

8. AGE: Years 58 | Months 8 | Days 9 | If less than one day 10 hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business AT HOME

FATHER
12. Name Peter Grossman
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Anna E Grau
15. Birthplace Balto. Md

16 (a) Informant Stephen Leo King
(b) Address 1732 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore National
Location 5300 Frederick Rd.

18 (a) Funeral director J. Walter Conklin
(b) Address 1448 Gorsuch Ave

(c) Filed (Date received by Registrar) OCT 4 1948 Huntington Woods Registrar

MEDICAL ~~CERTIFICATION~~

20. DATE OF DEATH Oct. 2, 1948, at 4.15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 1948 to Oct. 2, 1948, and that I last saw her alive on October 1, 1948.

	Duration
Immediate cause of death Respiratory Failure	
Due to Cardiac Insufficiency	
Due to Hypertensive Cardiovascular Disease.	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy: Congestive Heart Failure

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank W. Baker, Jr. M.D.
Address St. Joseph's Hosp. Date signed 10-2-48

93

VS 150

667340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170c

667340
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 North Durham St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS JOSEPH BURNS

3 (b) If veteran, name war
World War II

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1924

8. AGE: Years 23 | Months 10 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Policeman

11. Industry or business Baltimore City

FATHER
12. Name Thomas J. Burns
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Mes[illegible]ll
15. Birthplace Baltimore, Md.

16 (a) Informant: Mrs. Margaret Burns Said
(b) Address 1519 Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5th, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

OCT 4 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1948, at 12[05] PM

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull with
avulsion of brain tissue.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 26/4
(a) Date of injury 10-1-48 at approx. 9.20 a. M.
(b) Where did injury occur? Erdman Ave. & North Pt. Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? yes
(d) Means of injury Motorcycle and truck collision

23. Signature Howard J. Walters M.D.
Medical Examiner.
Date signed October 1, 1948

X

667341

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667341 Registered No. 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.U.H.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Pikesville Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 Clarendon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Veise (WILLIAM FERGUSON VEISE)

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mayfield W. Veise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1880

8. AGE: Years	Months	Days	If less than one day
~~xxxx~~ 68	7	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Gardner
11. Industry or business

FATHER
12. Name John Veise
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Ferguson
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. John J. Veise
(b) Address 17 Carendon Ave., Pikesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed 1948 (b) Registrar Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1948 at 8:05 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Fulmer M.D. Medical Examiner.
Date signed 10/7/48

X

Oal-6667342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

309

667342
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 S. Port St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Kresina
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	Married

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-8-03

8. AGE: Years	Months	Days	If less than one day
44	9	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Frank Kresiana
13. Birthplace Austria

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 7 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto. 31, Md.

19 (a) [illegible] (Signature of registrar) Thurlington Williams, M.D. Registrar

VS 392

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1948, at 9 14 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1948, to 10-2 1948, and that I last saw him alive on 10-2 1948.

immediate cause of death Multiple pulmonary infarcts & Congestive Heart failure — Duration

Due to Rheumatic Heart disease - inactive & mitral stenosis & mitral insufficiency & auricular fibrillation

Other Conditions Syphilis - late treated

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature H. H. Jackson
Address The Johns Hopkins Hosp. Date signed 10/3/48

M.D.

921

667343

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667343 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Virginia (b) County
(c) City or town Berkley Springs, W. Va.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Belle Merica

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 17 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Berkley Springs, W. Va. (Town, county, and state)

10. Usual Occupation student

11. Industry or business

FATHER
12. Name Herbert Merica
13. Birthplace St. John Run, W. Va.

MOTHER
14. Maiden Name Helen Miller
15. Birthplace Berkley Springs, W. Va.

16 (a) Informant The Seton Institute
(b) Address 6420 Reisterstown Rd., Balto. 15, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6, 48 (month) (day) (year)
(c) Cemetery or crematory Greenway
Location Berkeley Springs W. Va

18 (a) Funeral director Frank N. Merrill
(b) Address Pikesville, Maryland

19 (a) [illegible] (b) Huntington W. Va.
OCT 4 (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1948, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2-48 19..., to 10-3-48 19..., and that I last saw her alive on 10-3 1948.

Immediate cause of death
Pericardial effusion
Due to Sepsis
Due to acute Rheumatic Pancarditis

Duration 12 Days

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Pancarditis Rheumatic

PHYSICIAN
Underline the cause to which death should be directed statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Randolph P. Major M. D.
Address 33 W. Madison St. Signed

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

G67344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G67344 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4615 Mannasota Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Annabelle C. Roth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/11/83

8. AGE: Years	Months	Days	If less than one day
65	1	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Howard Meeks
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lydia Ringgold
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mildred Altenburg
(b) Address 4615 Mannasota Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6 1948 (month) (day) (year)
(c) Cemetery or crematory Westview Park
Location Edmondson Ave

18 (a) Funeral director John C. Moran
(b) Address 3600 E. Baltimore St

19 (a) (Date received by registrar) (b) Registrar

VS 50

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1948 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1948 to 10/3 1948 and that I last saw her alive on 10/3 1948

Immediate cause of death UREMIA

Duration

Due to Lowered plasma proteins, liver damage

Due to Obstructive jaundice, stone in common duct

Other Conditions Cholecystitis with cholelithiasis

(Include pregnancy within 3 months of death)

Date of operation 9/23/48

Major findings of operation: Acute cholecystitis, dilated common duct

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul G. Herold M. D.
Address Md. Gen. Hosp. Date signed 10/3/48

GR-48-21198

667345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. 667345

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Catonsville - 28, - Rural (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Delroy Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy. Kron

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/4/48

8. AGE: Years	Months	Days	If less than one day
		1	25 hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Stephen Joseph Kron
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elfrede Gadau
15. Birthplace Germany

16 (a) Informant Stephen J. Kron.
(b) Address Delroy ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/48 (month) (day) (year)
(c) Cemetery or crematory Bay Cathedral
Location Baltimore Md

18 (a) Funeral director Edgar Mar Hall
(b) Address Catonsville Md

19 (a) (Date received by registrar) Washington Mills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4/48 19 12:10A. M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/2 1948. to 10/4 1948. and that I last saw h alive on 10/3 1948.

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D Strohler M. D.
Address Bon Secours Hosp Date signed 10/4/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4-2a

Registered No. 667346

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Avenue
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6004 Falls Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Blanche Estelle Small

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph S. Small
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 17, 1888

8. AGE: Years	Months	Days	If less than one day
60	8	15	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Nathan Sewell
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan R. Hickey
15. Birthplace Virginia

16 (a) Informant Joseph S. Small
(b) Address 6004 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Mary's (Hampden)
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

OCT 4 - 1948 (Date rec'd by Registrar) (b) Huntington Ave Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1948 at 9:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1948 to Oct 2 1948 and that I last saw h[illegible] alive on Oct 2 1948

Immediate cause of death: cerebro vascular accident — Duration

Due to hemorrhage into temporal and parietal lobes, left

Due to hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Judith S. Landau M. D.

Address Date signed

VS 150

667347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. 667347

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2879 Chesterfield Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2879 Chesterfield Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOLORES MARION BARNES

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 213-26-9730

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 13, 1930

8. AGE: Years 18 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk - Vacation Time
11. Industry or business Stewarts

FATHER
12. Name Martin J. Barnes
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Frances A. Simmons
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Frances A. Barnes
(b) Address 2879 Chesterfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) OCT 4 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1948 at 8.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 1948 to Oct 2 1948.
and that I last saw h alive on Sept Oct 2 1948.

Immediate cause of death	Duration
Pernicious Anemia and Tuberculosis	
Due to T. Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin L. Ward M. D.
Address 313 St. Paul St. Date signed Oct. 4 48

VS 153

667.348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 667.348

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Phil. Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 3640 Chestnut St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT GRANGE HOLDEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Marie McDonald Holden
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1890

8. AGE: Years	Months	Days	If less than one day
57	10	21	10 hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Marine Captain
11. Industry or business

FATHER
12. Name George C. Holden
13. Birthplace Ohio

MOTHER
14. Maiden Name Elizabeth Middleton Holden
15. Birthplace Unknown

16 (a) Informant Marie McDonald Holden
(b) Address 3640 Chestnut St. Phila. Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 4, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Davids, Pa.
Location Pennsylvania

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 4 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1948, at 12:30 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural hematoma, Probable right

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-3-48 at Approx. 2 A. M.
(b) Where did injury occur? Found lying in doorway at Balderson & South Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Slipped and Fell to Ground

23. Signature Medical Examiner. M.D.
Date signed 10/4/48

VS 151

667349

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667349 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A.A. Co.
(c) City or town Pasadena (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred H. Kutter

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-09-9660

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Lena C Kutter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3 —

8. AGE: Years 64 | Months 5 | Days - | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Reinhold Kutter
13. Birthplace Ger

MOTHER
14. Maiden Name Marie Winkler
15. Birthplace Germany

16 (a) Informant Lena C Kutter
(b) Address Pasadena Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6/48 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Wash Blvd

18 (a) Funeral director Uhlenhuth Funeral Home
(b) Address 3[illegible] & Orleans St

19 (a) OCT 4 - 1948 (Date rec'd by registrar) Huntington Williams Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 3 — 1948 at 3 56 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25, 1948 to Oct 3, 1948 and that I last saw him alive on Oct 3, 1948.

Immediate cause of death	Duration
Lobar pneumonia	
Pulmonary and Splenic infection	
Due to Cardiac decompensation	
Due to Hypertensive cardiovascular Disease	
Other Conditions (1) Auricular fibrillation	
(2) Mural thrombus	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: no about

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — ; While at work?
(Specify type of place)
(e) Means of injury —

23. Signature William T. Hearn, M. D.
Address Sou. Balto Gen Hosp Date signed
Baltimore 20, Md 10-3-48

VS 150

G67350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121 R

G67350
Registered No.

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 267 Ballon St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Durkin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife Anthony Durkin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1905

8. AGE: Years	Months	Days	If less than one day
43	4	25	hr. 9 min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Daniel Hunt
13. Birthplace N. C.

MOTHER
14. Maiden Name Etta Gantter
15. Birthplace N. C.

16 (a) Informant husband
(b) Address 267 Ballon.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5-48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson Ave.

18 (a) Funeral director John K Ramsey
(b) Address Edgemere Md.

19 OCT 4 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1948, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1948, to 10-3 1948, and that I last saw her alive on 10-3 1948.

Immediate cause of death Uremic coma — Duration 4 da

Due to Chronic glomerular nephritis

Due to

Other Conditions Hypertensive C.V. disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq Hosp. Date signed 10-3-48

VS 190

667351 ✓ 667351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 4813

Registered No.

667351

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2203 Eastern ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Eastern ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna (Wawrowicz) Jelski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married.

6 (b) Name of husband or wife Joseph Jelski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Vincent Wawrowicz
13. Birthplace Poland

MOTHER
14. Maiden Name Zofia ?
15. Birthplace Poland

16 (a) Informant Joseph Jelski
(b) Address 2203 Eastern ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5 1948 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Baltimore City

18 (a) Funeral director John M. Weber
(b) Address 421 S. Chester Street

19 (a) 1948 (Date filed by registrar) Washington Williams Registrar

VS 3

MEDICAL CERTIFICATION 3 00

20. DATE OF DEATH October 1 1948 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1948 to Oct 1 1948, and that I last saw h[er] alive on Oct 1 1948.

Immediate cause of death Hypostatic Pneumonia — Duration Sept 28 '48

Due to Carcinoma of Uterus — Aug. 1948

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Reuwer M. D.
Address 901 Reedbird Ave. Date signed Oct 1 48

X

G67352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67352

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Queen Anne
(c) City or town Centerville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jeremiah Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-2-79

8. AGE: Years 69 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Farm Labor

11. Industry or business

FATHER 12. Name David Kennedy
13. Birthplace Md.

MOTHER 14. Maiden Name Healer ?
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof OCT 7-48 (month) (day) (year)
(c) Cemetery or crematory Burnside Md
Location Near Centerville Md

18 (a) Funeral director Edgar L. Lee
(b) Address Centreville Md (c) Kennington Delaware Md

19 (a) 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1948, at 8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1948 to 10/4 1948 and that I last saw him alive on 10/4 1948

Immediate cause of death Cancer of Prostate

Due to Blood

Due to with

Other Conditions metastases

(Include pregnancy within 3 months of death)

Date of operation 9/18/48

Major findings of operation: Ca of prostate

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Wm. F. Silver M.D.

Address J. H. H. Date signed 4 Oct. 48

VS 150

G67353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G67353

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2315 N. Calvert Street
(c) Hospital or institution: 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 N. Calvert Street (if rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edmond Boone Luckett

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Margie A. Luckett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 17, 1860

8. AGE: Years	Months	Days	If less than one day
88	5	15	hr. min.

9. Birthplace Hancock, Maryland (Town, county, and state)
10. Usual Occupation President - Retired
11. Industry or business Luckett Brickler Co.

FATHER
12. Name John R. B. Luckett
13. Birthplace Maryland

MOTHER
14. Maiden Name Maria Hall
15 Birthplace

16 (a) Informant Mrs. Margie Luckett
(b) Address 2315 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/48 - (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (Date rec'd by Registrar) OCT 5 - 1948 Washington Wholesale Mo. Year

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1948 at 8:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Oct 2 1948 and that I last saw h[illegible] alive on Oct 2 1948

Immediate cause of death	Duration
Bronchial Pneum	4 da
Due to	
Due to Arteriosclerosis	4 yr?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Edw. Talbert M. D.
Address 2723 St Paul Date signed 10/4/48

VS 150

73-46 LH 2.

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 667354 Registered No.

CERTIFICATE OF DEATH 161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Arnold
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 3, 1948

8. AGE: Years	Months	Days	If less than one day
			16 hr. 25 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alister C. Anderson
13. Birthplace

MOTHER
14. Maiden Name Frances Hutchins
15 Birthplace Balto. Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Asbury Church Cem.
Location Barstow, Calvert Co. Md.

18 (a) Funeral director John O. Mitchell Inc.
(b) Address 1900 Eutaw Place

19 (a) OCT 5 - 1948 (Date rec'd by registrar) Huntington Williams M.D.

VS 15)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1948, at 5.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from October 3 1948, to October 3 1948, and that I last saw her alive on October 3 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Atelectasis	17 hr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of ~~operation~~ autopsy Pulmonary atelectasis, edema, hemorrhage & of autopsy: G-I hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Harrison Clarke Spencer M.D.
Address Johns Hopkins Hosp Date signed 10-4-48

X

673355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

673355 Registered No.

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hr. 5min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 St. Anns Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: KATHERINE M. PAUL

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James Paul

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1908

8. AGE: Years 40 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Benjamin E Choffman
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Maud F. Freyee
15. Birthplace Garrett Co., Md.

16 (a) Informant Benjamin F. Choffman
(b) Address 605 St. Anns Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Belto., Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1948 at 10:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to compound fracture of skull

Due to Fracture of Pelvis & Laceration of scalp.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 1/3

(a) Date of injury Oct. 3/48 7:30 P.M.
(b) Where did injury occur? 25th St. & Guilford Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Hit and Run

23. Signature Emil Vogt M.D. (Medical Examiner)
Date signed 10/4/48

VS 151

67356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67356

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument & Rutland Ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 S. Grundy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Carmella Mosca — Carmela Mosca
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Francesco Or Frank
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr): Dec. 4 1889
8. AGE: Years 58 | Months 9 10 | Days - | If less than one day hr. min.
9. Birthplace: Italy (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Sebastian Stile
13. Birthplace: Italy

MOTHER
14. Maiden Name: Consilia Casgona
15. Birthplace: Italy

16 (a) Informant: Frank Mosca
(b) Address: 225 S. Grundy St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/48 (month) (day) (year)
(c) Cemetery or crematory: Oaklawn
Location: Eastern Ave.

18 (a) Funeral director: Frank Pelly Nose
(b) Address: 322 S. High St.

19 (a) OCT 5 1948 (Must not be filled by registrar) (b) Huntingtor Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-4 1948, at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1948, to 10-4 1948, and that I last saw her alive on 10-4 1948.

Immediate cause of death: Hypertensive Cardiovascular Renal.
Due to: Pos Cerebral Hemorrhage
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Jerome Gaber M. D.
Address: Sinai Hosp. Date signed 10-4-48.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1210

Registered No. 167557

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3021 Dona Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3021 Dona Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna K. Wittmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry Wittmer

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Jan 17th 1869

8. AGE: Years 79 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name John Vogel
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Roth
15. Birthplace Germany

16 (a) Informant Henry Wittmer
(b) Address 3021 Dona Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7th (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Wilson Funeral Home
(b) Address 2008 Orleans St

19 (a) OCT 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7th 1948, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1948, to Oct. 4 1948 and that I last saw her alive on Oct. 1 1948.

Immediate cause of death Uremia — Duration

Due to Catarrhal C.V.R.D.

Due to Marked arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Haas M.D.

Address 4212 Boyd Rd Date signed 10/4/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

7358

JL-115686

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667358
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Brunt St. -17 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Bertha Elizabeth Hawkins

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife John Thomas Hawkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1913

8. AGE: Years	Months	Days	If less than one day
35	-	6	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Roscoe Latimore
13. Birthplace S. C.

MOTHER
14. Maiden Name Irene Warnick
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Va Brookes
18 (a) Funeral director
(b) Address 1463 N. Carey St.
19 (a) OCT 5 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1948 at 11.50 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Dec. 5 1947 to Sept. 25 1948. and that I last saw him/her alive on Sept. 25 1948.

Immediate cause of death	Duration
Due to Pulmonary tbc	9 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature L Gayle Burton
Address Baltimore City Hospitals Date signed 10/5/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 703 S. Sharp St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Montgomery (Thomas)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1-48

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Clarence Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Helen Montgomery
15. Birthplace Sumter, S.C.

16 (a) Informant Helen Montgomery
(b) Address 703 S. Sharp St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director James A. Stayton
(b) Address 142 Wolfe St.

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Oct 1948 5 1/2 P M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify)
(d) Means of injury

23. Signature Earl Royer M.D. (Medical Examiner)
Date signed 30 Oct 48

VS 151

7360

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1,883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fourth St. & Chesapeake Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6207 Overall Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH W. STUMPFEL mp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1916

8. AGE: Years	Months	Days	If less than one day
32	2	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Joseph Stumpfel
13. Birthplace Austria

MOTHER
14. Maiden Name Emilie G. Quasney
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Emilie G. Quasney
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 5 1948 (Date rec'd by Registrar) (b) Issued Washington Boulevard Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1948, at 2.15pM

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Drowning

Due to

Other Conditions Simple Schizophrenia

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-3-48 at found 2.15 p. M.
(b) Where did injury occur? Arundel Cove
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury Drowning

23. Signature Earl L. Rogers M.D.
Medical Examiner.
Date signed October 4, 1948

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67361

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos. or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Milford Ave #7 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Schaunloeffel (Gertrude G. Schaunloeffel)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: C. Edward [illegible]aunloeffel

6 (c) If alive, [illegible] age years

7. Birth date of deceased (mo., day, yr.) March 28, 1885

8. AGE: Years 63 | Months 6 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Weaver
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Althea S. Eichert
(b) Address 2206 - 78th St., Jackson Hgts, N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6, 1948 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral Director Gilles & Amoran
(b) Address 4510 Liberty Heights Ave.

OCT 5 - 1948 (Date rec'd by Registrar)

(b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1948 at 4:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1948 to 10/3 1948 and that I last saw her alive on 10/3 1948

	Duration
Immediate cause of death: Cardio-respiratory failure	1 day
Due to: Uremia	5 days
Due to: Hypertensive C-V Renal Disease	12 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred H. Dann

Address Maryland General Hosp. Date signed M 10 D 3/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G67362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2230 Linden Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-2
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2230 Linden Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ALLEN H. KERNGOOD.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Bessie Kerngood 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1888.

8. AGE: Years	Months	Days	If less than one day
59	10	-	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Mnfgr's Agent.
11. Industry or business

FATHER
12. Name Herman Kerngood,
13. Birthplace Germany.

MOTHER
14. Maiden Name Mollie Mansbach,
15. Birthplace Germany.

16 (a) Informant Mrs. Bessie Kerngood,
(b) Address 2230 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director [illegible]
(b) Address 1902 Eutaw Place.

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1948, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948, to 10/4 1948, and that I last saw h[illegible] alive on Sept. 29 1948.

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis

Due to Cerebral vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
5 weeks
1 year

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Gardiner M. D.
Address 2117 SOUTH RD. Date signed 10/4/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67363

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4602 Roland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: HUNTER H. MOSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Amy Carr
6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) July 14, 1906

8. AGE: Years	Months	Days	If less than one day
42	2	20	hr. min.

9. Birthplace: Parkersburg W. Va. (Town, county, and state)

10. Usual Occupation: Lawyer
11. Industry or business

FATHER
12. Name: Hunter H. Moss
13. Birthplace: Parkersburg W. Va.

MOTHER
14. Maiden Name: Anna Ambler
15. Birthplace: Winchester, Va.

16 (a) Informant: Ambler H. Moss
(b) Address: Brooklandville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: Henry W. Jenkins, & Sons
(b) Address: York Rd. & Rossiter Ave.

19 (a) OCT 5 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1948, at 11:05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Barbiturate poisoning (nembutal)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 1/48 at M.
(b) Where did injury occur? Lord Baltimore Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? Hotel While at work? No
(d) Means of injury: Ingestion of sleeping pills

23. Signature: George G. Merrill M.D. Medical Examiner.
Date signed 10/4/48

G67364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67364

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address At Sea
(c) Hospital or institution:
Sent to Balto. City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S.C. (b) County
(c) City or town Charlestown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 135 Ashley Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME CHARLES B. FERGUSON

3 (b) If veteran, name war

3 (c) Social Security Account No. 247-14-1674

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Leila Ferguson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1900

8. AGE: Years	Months	Days	If less than one day
48	0	4	hr. min

9. Birthplace
(Town, county, and state)

10. Usual Occupation Merchant Mariner

11. Industry or business Pan American Petroleum Transport Co.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Capt. L. C. McKay
(b) Address 122 E. 42nd St., N.Y.City

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-5-48 (month) (day) (year)

(c) Cemetery or crematory
Location Charleston, S.C.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1948, at ? M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rogge M.D.
Medical Examiner
Date signed October 4, 1948

G67365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G673365

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 Division STREET
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) h.f.c.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6. E. Hamilton (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELENA BROWNE HEARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Chauncey Brown

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) January 17, 1870

8. AGE: Years 78 | Months 7 | Days 16 | If less than 1 day hr min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Seaman Brown
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mahaly PETERS
15. Birthplace Baltimore, Md.

16 (a) Informant Harold Heard.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Holland Funeral Home
(b) Address 1631 Druid Hill Ave.

19 OCT 5 - 1948 (Date rec'd by registrar) (b) Filed Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 2ND 1948 at 4:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1948 to OCT 2nd 1948. and that I last saw h[illegible] alive on OCT 1st 1948

Immediate cause of death Renal failure - Duration 3 weeks

Due to Hypertensive Cardio-renal disease 24 yrs.

Due to

Other Conditions Congestive failure.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W.M. Masserdin Jr. MD

Address Provident Hospital Date signed 10-2-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. 67306

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1109 Etting St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Etting St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella Hanley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 12, 1875

8. AGE: Years: 72 | Months: 11 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Easton, Md. (Town, county, and state)

10. Usual Occupation: Maid

11. Industry or business

FATHER — 12. Name: James Grace

FATHER — 13. Birthplace: Easton, Md.

MOTHER — 14. Maiden Name: Annie Moody

MOTHER — 15. Birthplace: Easton, Md.

16 (a) Informant: Mrs. Margaret Byrd

(b) Address: 1109 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 5, 1948 (month) (day) (year)

(c) Cemetery or crematory: Mt. Auburn

Location: Baltimore, Md.

18 (a) Funeral director: Mrs. Lange & Holland

(b) Address: 1631 Druid Hill Ave.

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

10-1-1948

20. DATE OF DEATH 10-1— 1948. at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28— 1948. to 10-1— 1948. and that I last saw her alive on 9-30— 1948.

Immediate cause of death: Chronic myocarditis — Duration

Due to

Due to

Other Conditions: Congestive heart failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: C.R. Campbell M. D.

Address 718 Dolphin St. Date signed 10-4-48

VS 150

667367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 667367

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 Light St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Light St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Grace V. Jenkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Arthur S. Jenkins | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14-1901

8. AGE: Years 46 | Months 11 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Bayner
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Baltimore Md.

16 (a) Informant Arthur S. Jenkins
(b) Address 1714 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5, 1948 (month) (day) (year)

(c) Cemetery or crematory Glen Haven
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) OCT 5 - 1948 (Date rec'd by Registrar) (b) Washington Ave Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2/48 19 , at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from September 19 47 to Oct 2 1948.
and that I last saw h[illegible] alive on 10/1/1948.

Immediate cause of death	Duration
Carcinoma of Stomach	1 year
Due to	
Due to	
Other Conditions Cachexia Abdominal Ascite (Include pregnancy within 3 months of death)	3 mos

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Muller M. D.
Address 1228 N Charles St. Date signed 10/3/48

VS 250

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G67368

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 N. Wolfe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 N. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME West Mobley

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-10-9476

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Daisy Mobley

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr) 1902

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace Chester Co. S. C.
(Town, county, and state)

10. Usual Occupation Truck man

11. Industry or business

FATHER
12. Name George Mobley
13. Birthplace Chester Co. S. C.

MOTHER
14. Maiden Name Mary Moore
15. Birthplace Chester Co. S. C.

16 (a) Informant Daisy Mobley
(b) Address 420 N. Wolfe St

17 (a) Burial (b) Date thereof Oct. 5-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park
Location Arbutus Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Blantey ave

1948 OCT 5 1948 (b) Huntington Williams M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

Oct. 2-48 556

20. DATE OF DEATH Oct. 2 1948, at 556 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1948 to Oct 2 1948
and that I last saw h alive on Oct 1 1948

Immediate cause of death Congestive Heart failure

Duration 7 yrs

Due to Hypertensive Cardio Vascular Disease ?

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Williams M. D.
Address 222 N. Caroline Date signed Oct 4 48

667369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 667369

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1019 Valley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Mary Widman

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: George H. Widman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 1872

8. AGE: Years	Months	Days	If less than one day
76	7	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at home

FATHER
12. Name Thomas Bacher
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Hoban
15. Birthplace Ireland

16 (a) Informant Mr. George H. Widman
(b) Address 1019 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Holy Redeemer
Location 4430 Belair Rd

18 (a) Funeral director Edgar W. Conklin
(b) Address 924 E. Eager St.

19 (a) D.C. Oct 5 1948 (Date rec'd by Registrar) (b) Washington Williams, M.D. Registrar

V 15 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1948, at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1948 to 10-3 1948, and that I last saw h.er alive on 10-2 1948.

Immediate cause of death: Bronchopneumonia — Duration: 2 days
CERTIFICATION APPROVED BY
Due to
Due to Howard J. Madeira M.D.
CHIEF OR ASST. MEDICAL EXAMINER
Other Conditions: Fractured Right Hip — 4 weeks
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 10/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence September 16 at ? P.M.
(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury slipped and fell to floor

23. Signature [illegible] M. D.
Address 11 E. Chase St. Date signed 10-4-48

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

667370

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

667370 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2023 Brunt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2023 Brunt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Stanley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age 89 years

7. Birth date of deceased (mo., day, yr.) March 12, (1885)

8. AGE: Years	Months	Days	If less than one day
58	6	21	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Stanley
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Cole
15. Birthplace Maryland

16 (a) Informant Elizabeth Stanley Evans
(b) Address 1833 Druid Hill Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/26 (month, day, year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Edgar T. Nelson
(b) Address 1303 Eastern Ave

19 (a) OCT 5 1926 (Date received by local registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2 1926 at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autop. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Orlando M.D.
Medical Examiner.
Date signed 10/3/26

VS 151

Please answer all questions. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

657371 SC-48,9/30

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. 657371

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Avenue
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 N. Castle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Linnemen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1948

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Stuart Linnemen
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Jeannette Irene Simpson
15. Birthplace Severn, Maryland

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location S. A. Med. School 11/30/48

18 (a) Funeral director
(b) Address

19 (a) 10/5/48 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1948 to Sept 13 1948. and that I last saw her alive on Sept 13 1948.

Immediate cause of death	Duration
Subarachnoid Hemorrhage	
Due to Birth Injury?	
Due to	
Other Conditions Prematurity Incomplete Cleavage of Lungs (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S A Warren M.D.
Address Sinai Hospital Date signed Oct 7/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

167,572 BC-48-20620 V 167,572

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 167,572 16 1c

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Clark

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negroe	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/27-48

8. AGE: Years	Months	Days	If less than one day
0	0	0	0 hr. 22 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Charlie Clarke
13. Birthplace North Carolina

MOTHER
14. Maiden Name Beanie Clarke
15. Birthplace North Carolina

16 (a) Informant Hospital Records
(b) Address 601 North Broadway

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) OCT 5 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from , 19 , to , 19 , and that I last saw h alive on , 19 .

Immediate cause of death Asphyxia — Duration

Due to

Due to Intrapartum Stress

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul D. Brown M.D.
Address Date signed 10-8-48

673573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 B

673573 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Park Drive & 31st Street

(c) Hospital or institution: U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 62 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County -

(c) City or town 3011 Pulaski Highway (If outside city or town limits, write RURAL and give town)

(d) Street No. Baltimore (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME PIORUNSKI, LEONARD JOSEPH

3 (b) If veteran, name war: WW 2

3 (c) Social Security Account No. unk219-12-6305

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	m

6 (b) Name of husband or wife: RITA PIORUNSKI

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 2, 1924

8. AGE: Years	Months	Days	If less than one day
24	7	1	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER — 12. Name: Joseph Piorunski

13. Birthplace: Balto, Md.

MOTHER — 14. Maiden Name: Mary Glass

15. Birthplace: Balto, Md.

16 (a) Informant: Records

(b) Address: U. S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (month) (day) (year)

(c) Cemetery or crematory: Holy Rosary

Location: Baltimore

18 (a) Funeral director: Philip Henry Sons

(b) Address: 2024 Orleans St

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (b) Huntington Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1948 at 8:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2, 1948 to Oct. 3, 1948 and that I last saw him alive on October 3, 1948

Immediate cause of death: 1-Hodgkin's Disease — Duration: 3 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John L. Wilson

Address: Clinical Director, M. D. Date signed Oct 4,48

VS 150

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67374

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67374 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 53rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4201 Diller Ave (If rural give location)
(e) Citizen of foreign country? — ~~Yes or~~ No) If yes, name country —

3 (a) FULL NAME: Mrs. Harry A. Felling (Catherine) CATHERINE ANN ELIZABETH FELLING

3 (b) If veteran, name war: ~~NO~~
3 (c) Social Security Account No. ~~NONE~~

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Harry A. Felling
6 (c) If alive, give age 55 years
7. Birth date of deceased (mo., day, yr.) April 3, 1883
8. AGE: Years 65 | Months 6 | Days 0 | If less than one day — hr. — min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Charles L. Sims
13. Birthplace Maryland

MOTHER
14. Maiden Name Lola Thomas
15. Birthplace Maryland

16 (a) Informant Mr. Harry A. Felling
(b) Address 4201 Diller Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (month) (day) (year)
(c) Cemetery or crematory Jerusalem Church Cem. Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1948, at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 17 1948 to Oct. 3 1948 and that I last saw her alive on Oct. 3 1948.

Immediate cause of death: Cerebral embolus — Duration: 5 days
Due to: Mural Thrombi - heart — weeks
Due to: Arteriosclerotic heart disease — years
Other Conditions: multiple pulmonary emboli
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature M. R. Cox M.D.
Address Union Memorial Hospital Date signed 10-5-48

VS 150

667375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

ES- 119381

X ✓ 667375 Registered No. 47c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 31 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 7010 Fait Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andy Hill (ANDREW HILL)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-07-3575

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife: Alma ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 7, 1881

8. AGE: Years 67 | Months 0 | Days 28 25 | If less than one day hr. min.

9. Birthplace Finland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Bethlehem Steel Co.

FATHER 12. Name Henry Hill (Andrew Hill)

FATHER 13. Birthplace Finland

MOTHER 14. Maiden Name Ida Hill

MOTHER 15. Birthplace Finland

16 (a) Informant RECORDS- BALTO. CITY HOSPITALS

(b) Address 4940 EASTERN AVE.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/5/48 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 (a) OCT 5 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2- 1948 at 10:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-2- 1948 to 10-2 1948, and that I last saw h im alive on 10*2 1948.

Immediate cause of death – Bronchogenic Carcinoma — Duration Months

Due to Bronchial Pneumonia terminal

Due to ? Cerebral metastasis

Generalized coronary

Other Conditions Sclerosis

(Include pregnancy within 3 months of death)

Date of operation —o

Major findings of operation: —o

of autopsy: ABOVE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Warren E Porter M.D.

Address Balto. City Hospitals Date signed 10/4/48

X

VS 130

667376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667376

30-C-28570 104a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: EDWARD R. SOKAL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1945

8. AGE: Years 3 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Edward Sokal
13 Birthplace Stuebenville, Ohio

MOTHER
14. Maiden Name Margaret Newschaffer
15. Birthplace Baltimore, Maryland

16 (a) Informant Margaret Sokal (mother)
(b) Address 1919 E. Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Balto. County

18 (a) Funeral director John M. Weber
(b) Address 404 S. Chester Street

19 OCT 6 - 1948 (Date rec'd by registrar) (b) Twentyfour Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1948, at 8 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Upper respiratory infection
Acute dilatation of heart,
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10/2/48

VS 181

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 67377

Please write clearly with pen and ink. Physicians: please write the causes of death clearly and legibly. Do not abbreviate. Entries must be complete. Cemetery supplies the information for items 17 (a), (b), (c).

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Low Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CORA MILLS

3 (b) If veteran, name war no

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Ernest

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-1-1904

8. AGE: Years 44 | Months 1 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Frederick, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant James Dorsey
(b) Address 1342 Mosher Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10-5-48 (month)
(c) Cemetery or crematory Balto. National Cemetery
Location Baltimore, Maryland

18 (a) Funeral director C. G. Cooper
(b) Address 512 N. Carrollton Avenue

19 (a) OCT 5 - 1948 (Date rec'd by registrar) **(b)** Huntington Williams Mort

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1948, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L Rose M.D.
Medical Examiner.

Date signed 9-30-48

667378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667378 Registered No. 1248

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 652 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY CRICKENBERGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 25, 1911

8. AGE: Years	Months	Days	If less than one day
37	1	9	hr. min.

9. Birthplace Green County, Virginia (Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business Restaurant

FATHER
12. Name Robert Shipp
13. Birthplace Green County, Virginia

MOTHER
14. Maiden Name Ida Gorden
15. Birthplace Green County, Virginia

16 (a) Informant Floyd Shipp
(b) Address Rockesville, Virginia

17 (a) (Burial, cremation, or removal) (b) Date thereof 10-6-48 (month) (day) (year)
(c) Cemetery or crematory
Location Rockesville, Va.

18 (a) Funeral director (CLORE) J. Carlton Clore by Jos. Kelly
(b) Address Cid Green, Va

19 (a) OCT 5 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1948, at 9.00 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fatty degeneration of liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed October 2, 1948

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 667379

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3030 Baker St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 Baker St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll W. Haines

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ethel M. Haines

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr) August 20, 1885

8. AGE: Years 63 62 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Medford, Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Railway Express, Inc.

FATHER
12. Name Ephriam Haines
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Jane Cassell
15. Birthplace Md.

16 (a) Informant Mrs. Ethel M. Haines
(b) Address 3030 Baker St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-1948 (month) (day) (year)
(c) Cemetery or crematory Winter's Cemetery
Location Carroll Co., Md.

18 (a) Funeral director D. Howard Storey
(b) Address 3207 W. North Ave.

19 (a) OCT 5 - 1948 (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1948 at 11.00 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 31 1948 to Oct. 4 1948. and that I last saw h alive on Oct. 4 1948.

Immediate cause of death Coronary Thrombosis (2 attacks)
Due to Arteriosclerotic Cardio-Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 8 mos
?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F. Lerner
Address 2401 N. North Ave. Date signed Oct. 6, 1948

VS 150

Please write plainly. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667380

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Mount Inc, 3706 Nortonia Road
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4209 Penhurst Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Anna Elizabeth Roth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Lewis A. Roth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2 1884

8. AGE: Years	Months	Days	If less than one day
64	4	3	hr. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: At home
11. Industry or business

FATHER
12. Name: Matthew J. Finn
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Elvira Clark
15. Birthplace: Virginia

16 (a) Informant: Lewis A. Roth
(b) Address: 4209 Penhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8 1948 (month) (day) (year)
(c) Cemetery or crematory: Fort Lincoln
Location: Maryland

18 (a) Funeral director: Harry Kornacker
(b) Address: 4204 Ridgewood Ave

19 (a) OCT 5 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1948, at 8:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19— to Oct 5 1948.
and that I last saw her alive on Oct 5 1948.

Immediate cause of death	Duration
Uremia. Heart failure	
Due to Hypert. C.V. Disease Arteriosclerosis.	
Due to [illegible]	
Other Conditions Bronchopneumonia left lung front	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: /
of autopsy: /

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide /
(b) Date of occurrence / at M
(c) Where did injury occur? / (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? / While at work?
(Specify type of place)
(e) Means of injury /

23. Signature: Kurt Levy M. D.
Address [illegible] Date signed 10/5/48

VS 150

Kurt Levy

667381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

667381 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2220 Lyndhurst Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 2220 Lyndhurst Ave (If rural, give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Bertha O. Cohen (Bertha .O. Cohen)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female White

5. Color or race

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2 1886

8. AGE: Years 62 | Months 2 | Days 23 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Levi Oppenheimer
13. Birthplace Germany

MOTHER
14. Maiden Name Rachael Stern
15. Birthplace Germany

16 (a) Informant [illegible]
(b) Address 3821 Garrison Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/48 (month) (day) (year)
(c) Cemetery or crematory Herzl Friendship Cem
Location Baltimore County Md

18 (a) Funeral director J. Epstein & Co
(b) Address 1 E. Preston St

19 (a) OCT 5 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948 at 10.03 M

21. I certify that death occurred on the date above stated, that I attended deceased from August 1941 to Oct. 5 1948. and that I last saw h alive on October 5 1948.

Immediate cause of death	Duration
Coronary thrombosis	½ hr.
Due to Chronic Hypertension	7 yrs
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertha Tapman Stamer
Address 3300 West North Ave Date signed 9/5/48

V8 8

667382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667382

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyoming Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 38 G. St, SW, Washington, DC (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME HODGE, CHARLES RODGER

3 (b) If veteran, name war: WW 1

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
m	c	w

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 17, 1895

8. AGE: Years	Months	Days	If less than one day
53	7	16	hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)

10. Usual Occupation machine operator

11. Industry or business U. S. Government

FATHER
12. Name Rodger Hodge
13. Birthplace Md

MOTHER
14. Maiden Name Lucy Maxfield
15. Birthplace Va

16 (a) Informant Record
(b) Address U. S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery or crematory Arlington Hall
Location Arlington, Va

18 (a) Funeral director Wheatley Farms Co
(b) Address 1432 You St NW Washington, D.C.

19 (a) OCT 5 - 1948 (Date rec'd by registrar) Registrar

V S 150 11-178

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1948, at 2:40PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12, 1948 to Octo. 3, 1948 and that I last saw him alive on Oct. 3, 1948

Immediate cause of death: 1-Osteogenic sarcoma of skull — Duration: 1 year

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson M. D.
Address Clinical Director Date signed 10-5-48

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667383

667383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1216

LCH 123509

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6104 Plantview (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME TONY PRIVITERA

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Alice

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 12/28/19

8. AGE: Years 28 Months 9 Days 4 If less than one day hr. min

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Privitera (d)
13. Birthplace ?

MOTHER
14. Maiden Name Catherine ?
15. Birthplace

16 (a) Informant Balto. City Hosp. records
(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-6-48 (month) (day) (year)
(c) Cemetery or crematory Washington D.C.
Location

18 (a) Funeral director W. W. Chambers
(b) Address Washington D.C.

19 (Date rec'd by registrar) 10-6-1948 (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5/48 at 12:40 PM

21. I certify that death occurred on the date above stated that I attended deceased from 9/27/48 to 10/5/48.
and that I last saw h im alive on 10/5/48

Immediate cause of death
(a) Uremia
Due to Chronic glomerulo-nephritis
Due to
Other Conditions

Duration
(a) 10 days
?

(Include pregnancy within 3 months of death.)
Date of operation
Major findings of operation:
of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William D. Kuhn M.D.
Address Balto City Hosp Date signed 10/6/48

067384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55c

Registered No. 067384

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp Women Md
(d) Length of stay in hospital or inst. (~~years, months~~ or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL, and give town)
(d) Street No. 45 Penn Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country —

3 (a) FULL NAME Gertrude Missoura Null

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan - 22 - 1877

8. AGE: Years	Months	Days	If less than one day
71	8	17 | 4	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Samuel Null
13. Birthplace Penn.

MOTHER
14. Maiden Name Hebbi Lippy
15. Birthplace Penn.

16 (a) Informant Mrs. J. D. Parker
(b) Address 3304 Alto Rd - Balto-16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8 1948 (month) (day) (year)
(c) Cemetery or crematory Knilers
Location Carroll Co

18 (a) Funeral director Jr Bankard. Son
(b) Address Westminster Md

19 (a) Date rec'd by Registrar OCT 6 1948 (b) Thurlington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 5 - 1948, at 7 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1948 to Oct - 5 - 1948, and that I last saw her alive on Oct - 5 - 1948.

Immediate cause of death	Duration
Pulmonary oedema	
Due to Carcinoma of Thyroid	
Due to	
Other Conditions Pericarditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Carcinoma of Thyroid

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary H. Lobe Lininger M. D.
Address Hosp. Women Md. Date signed X - 6 - 48

VS 150

PRINT OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1927

667385 Registered No.

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Johns Hopkins Hosp.

(c) Hospital or institution: Hosp. Women. Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2300 Callow St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME William Everett Schol3

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Schol3

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Apr - 17 - 1882

8. AGE: Years 66 | Months 5 | Days 13 | If less than one day: hr. min. 17

9. Birthplace Baltimore City (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name ? Schol3

13. Birthplace Not known

MOTHER 14. Maiden Name Madeline ? Schol3

15. Birthplace Not known

16 (a) Informant Mildred Sister McMullen

(b) Address 2300 Callow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-28 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Park

Location Balto Co. Md.

18 (a) Funeral director Wm Cooke Inc.

(b) Address 121 St Paul St

19 OCT 6 1928 (Date received by Registrar) (b) Huntington Maryland, Md.

VS 150 11a

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 4 - 1928 at 2 15 M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct - 4 - 1928, to Oct - 4 - 1928, and that I last saw h[illegible] alive on Oct - 4 - 1928.

Immediate cause of death	Duration
Cerebro Vascular Accident	
Due to Arterio sclerotic - Hypertensive Cardio vascular	
Due to Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George H. Yohlinger M. D.

Address Hosp. Wom. Md. Date signed X - 4 - 28

X

7386 Order 6
474392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67386

Registered No. 518

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Pa. (b) County

(c) City or town Frankstown (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James H. Spidel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Clara Spidel

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr) 1-23-81

8. AGE: Years	Months	Days	If less than one day
67	8	12	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER 12. Name John Spidel

13. Birthplace Pa.

MOTHER 14. Maiden Name Elizabeth Rattle

15. Birthplace Pa.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 6 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem.

Location Baltimore Md.

18 (a) Funeral director Fulton Oursler

(b) Address 1917 E. Fayette St.

19 (a) OCT 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948, at 7:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14-48 1948, to 10-5 1948, and that I last saw him alive on 10-5 1948

Immediate cause of death Subarachnoid hemorrhage — Duration

Due to Bleeding tendency - reduced platelets

Due to Pancytopenia - etiology undetermined

Other Conditions Probable Carcinoma of Prostate

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature D. Jackson

Address The Johns Hopkins Hosp Date signed 10/6/48

VS 150

667.587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

667387

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Baltov Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph (Fine) Fein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Elliott (Fine) Fein
13. Birthplace Russia

MOTHER 14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Mr Abe Garron
(b) Address 904 Whitelock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cem
Location Mt Carmel Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1184-1126 W North Ave

19 (a) OCT 6 1948 (Date rec'd by registrar) Washington Hebrew Cong

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1948. at 8:20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature M.D. (Medical Examiner.)
Date signed 10/4/48

VS 181

Please type or print plainly. Physicians: please write the causes of death clearly and legibly. Use ages in especially important.

667388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

667388 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2664 LAURETTA AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Y
(e) Length of stay in Baltimore (yrs., mos., or days) 25 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2664 LAURETTA AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country NO.

3 (a) FULL NAME MANSFIELD FERRELL

3 (b) If veteran, name war

3 (c) Social Security Account No. 283-10-2361

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife AGNES P. FARRELL 6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. JAN 1. 1884

8. AGE: Years	Months	Days	If less than one day
64	9	3	hr. min.

9. Birthplace CHARLESTON W. VA. (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business U.S.A.

MOTHER—FATHER
12. Name JOHN. FERRELL
13. Birthplace CHARLESTON W. VA.
MOTHER
14. Maiden Name KATHERINE BALL
15. Birthplace CHARLESTON W. VA.

16 (a) Informant AGNES P. FERRELL
(b) Address 2664 LAURETTA AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT 7-48 (month) (day) (year)
(c) Cemetery or crematory BALTO. NATIONAL
Location BALTIMORE

18 (a) Funeral director JOHN. T. STANSBURY
(b) Address 2300 EDMONDSON AVE.

19 (a) OCT 6 1948 (b) Huntington, Md.
(Date of burial)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 4 1948, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to 10-4 1948 and that I last saw h alive on 10-1-48 1948

Immediate cause of death myocardial failure
Due to coronary thrombosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 1 day, 3 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry S. Gimbel M. D.
Address 2702 Edmondson Date signed 10-4-48

X

667389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. 667389

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 S. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME PETER J. HUNT

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NO

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Mary Hunt

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) JUNE 20, 1881

8. AGE: Years 67 | Months 3 | Days 13 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: William J. Hunt
(b) Address: 308 Westshire Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7-48 (month, day, year)
(c) Cemetery or crematory: Holy Cross.
Location: A.A.Co

18 (a) Funeral director: John T. Stansbury
(b) Address: 2700 EDMONDSON AVE

OCT 6 - 1948 (Date rec'd by Registrar) Tennington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1948, at 2.10 P.M.

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation due to Self Administering Gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-3-48 at approx. 1.45 P. M.
(b) Where did injury occur? 3 S. Fulton St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Hose attached to gas pipe

23. Signature Emil L. Kayle M.D. Medical Examiner.
Date signed 40 Oct

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67390

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 No Chester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Rudman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 84 | Months 2 | Days | If less than one day hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation: retired

11. Industry or business

FATHER
12. Name: Not Known
13. Birthplace: Russia

MOTHER
14. Maiden Name: Not Known
15. Birthplace: Russia

16 (a) Informant: Nathan Rudman
(b) Address: 1641 Poplar Grove St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-48 (month) (day) (year)
(c) Cemetery or crematory: Mt Carmel
Location: Herring Run

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 210 Eutaw Place

19 (a) 10-6-1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 5 1948, at 10:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1948 to 10/5 1948, and that I last saw h[illegible] alive on 10/5 1948.

Immediate cause of death: Pulmonary Edema — Duration

Due to: Atherosclerotic and Hypertensive Heart Dis.

Due to:

Other Conditions: Pneumonia and Pulmonary Contusions
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Above.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Irving Feffer, M.D.
Address: Sinai Hosp. Date signed 10/5/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42E

G67391 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2704 N. Howard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 N. Howard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Rosier.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Wm Rosier.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5 [illegible]7

8. AGE: Years	Months	Days	If less than one day
90 91	11	29	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Augustus C. Almony.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant Mrs. Eva Almony.
(b) Address 2704 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7/48 (month) (day) (year)
(c) Cemetery or crematory New Market
Location Balto. Co. Md.

18 (a) Funeral director Faustina E. Donovan
(b) Address 3638 Roland Ave.

19 (a) OCT 6 - 1948 (Date received by registrar) (b) Huntington Pharmacy Md.

VS 150

MEDICAL CERTIFICATION

p.

20. DATE OF DEATH October 4, 1948, at 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Oct 4 1948, and that I last saw h[illegible] alive on Oct 2 1948. [illegible]

Immediate cause of death [illegible] Heart — Duration 1 hr.

Due to Coma - Cerebral Hemorrhage — Duration 10 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2524 E. Pratt St. Date signed Oct 5-48

X

57392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G67392

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Annabel Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Rodella Lowman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Guy K. Lowman

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) April 6, 1877

8. AGE: Years 71 | Months 5 | Days 27 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER 12. Name Samuel Newton

13. Birthplace Md

MOTHER 14. Maiden Name Mary E. Baldwin

15. Birthplace Md

16 (a) Informant Arthur Lowman

(b) Address 424 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/48 (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Annapolis Blvd

18 (a) Funeral director John F. Denny Inc

(b) Address 715 Eight St.

OCT 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, MD

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3- 1948, at 11 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27-1948, to 10-3-1948, and that I last saw her alive on 10-3-1948.

Immediate cause of death (1) Diabetes Mellitus — Duration

Due to

Due to

Other Conditions Generalized Arteriosclerotic Heart Disease (Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature William T. Hamm, M.D.

Address 500 Dalto Hen Hosp Baltimore 30, Md Date signed 10-3-48

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

67393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G67393

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3507 W. Rogdrs Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3507 W. Rogers Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME HENRY GLAUM

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elizabeth Glaum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1881

8. AGE: Years	Months	Days	If less than one day
67	1	26	hr. min.

9. Birthplace Owings Mills, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Henry Glaum

13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mr. Norman Glaum

(b) Address

17 (a) Burial (b) Date thereof 10/7/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Thomas Cem.

Location Garrison Forest, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 6 - 1948 (b) Huntington Ave. Baltimore, Md.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1948 at 7:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1948 to Oct 4 1948 and that I last saw him alive on Oct 4, 1948

Immediate cause of death	Duration
Myocardial Infarct	
Due to Acute Coronary Thrombosis	
Due to Arterio-Sclerotic Heart Disease	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Julius C. Glaum M. D.

Address 5356 Reisterstown Rd Date signed 10/5/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G67394

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 N. Hilton Road
(c) Hospital or institution: Shriner Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Filbert

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife: Single
6 (c) If alive, give age years

7. Birth-date of deceased (mo., day, yr.) April 15, 1861

8. AGE: Years	Months	Days	If less than one day: hr.	min.
87	5	20		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Filbert
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Feldpush
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Wm. G. McLaughlin
(b) Address 2204 Kentucky Ave. 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pennsylvania Ave. Balto.

19 (a) OCT 6 1948 (Date received by registrar) (b) ~~Huntington Williams, M.D.~~

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1948, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 31st 48 to Oct 4th 1948 and that I last saw her alive on Oct 4th 1948

Immediate cause of death	Duration
Myocardial Insuffiency	1day
Due to Cardio renal vascular disease	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. N. Nelson M.D.
Address 617 W. 40th St Date signed 10/6/48

VS 150

673395 ✓ 673395

A 65-831

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Turners Station (If outside city or town limits, write RURAL and give town)
(d) Street No. 545 Main St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Melvin Wylie,
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Col	

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min
	3			

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Melvin & Carrol
13. Birthplace Va.

MOTHER
14. Maiden Name Helen Wylie
15. Birthplace S. C.

16 (a) Informant:
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7. 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md
18 (a) Funeral director Eugene O Wilson
(b) Address 1000 Burgundy ave Huntington Wallace, Md.

OCT 6 - 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 - 1948 at 11 P M 35

21. I certify that death occurred on the date above stated; that I attended deceased from 10 - 1 - 1948 to 10 - 3 - 1948 and that I last saw him alive on 10 - 3 - 1948.

Immediate cause of death: Congenital Cardiac malformation — Duration

Due to

Due to

Other Conditions ? left polycystic Kidney

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify)
(e) Means of injury

23. Signature John T Ryan
Address Johns Hopkins Hosp Date signed 10 - 5 - 48 (M) (D)

VS 189

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667396

ES-123347

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667396 Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N. Chapel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Elmira Chase

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?

8. AGE: Years 89? Months Days If less than one day hr min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name UNABLE TO OBTAIN ANY FURTHER
13. Birthplace INFORMATION.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS.
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem. Location Baltimore, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Edmondson Ave

19 (a) 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1 (mo) 48 (yr) 6:00 A M

21. I certify that death occurred on this date at time stated; that I attended deceased from 9-28 (mo) 48 to 10-1 (mo) 48 and that I last saw her alive on 10-1 (mo) 48

Immediate cause of death: Bronchopneumonia, terminal — Duration: 3 days.
Due to
Due to
Other Conditions: Generalized arteriosclerosis — 10 yr.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Bronchopneumonia; arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Stutzman M. D.
Address Balto. City Hosp. Date signed 10-2-48

VS 150

667397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

667397

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Road (Entering Zuno)
(c) Hospital or institution:
Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 Barnes Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dolores McLean

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1938

8. AGE: Years	Months	Days	If less than one day
10	2	19	hr. min.

9. Birthplace Baltimore, Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Sylvester Wilson
13. Birthplace Unknown

MOTHER
14. Maiden Name Eula McLean
15 Birthplace Unknown

16 (a) Informant Mother, Eula McLean
(b) Address 1918 Barnes St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7-48
(month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Baltimore, Md.

18 (a) Funeral director Elroy S. Wilson
(b) Address 1000 Bentley Ave

19 (a) 10-8-48 (Date received by registrar) (b) Huntington Public Health

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4/ 1948, at 12:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24/ 1948, to 10/4/ 1948, and that I last saw her alive on 10/3/ 1948.

Immediate cause of death Tuberculous meningitis — Duration 9½ mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard M. Lyday M. D.

Address Sydenham Hospital Date signed 10/4/48

V S 150

667398 LCH 123322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667398 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 E. Lexington Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Ben Handy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65				

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER — 12. Name Ben Handy
13. Birthplace Maryland

MOTHER — 14. Maiden Name Annie ?
15. Birthplace Maryland

16 (a) Informant Balto. City Hosp. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. County, Md.

18 (a) Funeral director Joseph D. Koch, Jr.
(b) Address 1304 N. Central Ave

19 (a) (b)

OCT 8 1948 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1948 at 2:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/27/48 to 10/2 1948 and that I last saw him alive on 10/2/48

Immediate cause of death Lobar Pneumonia, Bronchopneumonia, right and mesenteric — Duration 1 wk.

Due to

Due to

Other Conditions Arteriosclerotic Heart Disease (Include pregnancy within 3 months of death) — 2 years

Date of operation

Major findings of operation:

of autopsy Bronchopneumonia, toxic nephritis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Stutzman M. D.
Address Balto. City Hosp. Date signed 10-4-48

X

667399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

667399 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 Elmtree Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FELICIA OLESCUK

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-28-6133

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Boleslaw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1, 1891

8. AGE: Years 57 | Months 7 | Days 4 | If less than one day: hr. min.

9. Birthplace Litvia
(Town, county, and state)

10. Usual Occupation Charwoman

11. Industry or business B lto. Trust Bldg.

FATHER
12. Name Maarbett Wallis
13. Birthplace Litvia

MOTHER
14. Maiden Name
15. Birthplace Litvia

16 (a) Informant Boleslaw Olescuk
(b) Address 1522 Elmtree St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9, 1948 (month) (day) (yr.)
(c) Cemetery or crematory Holy Cross
Location A.A. County

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave.

19 (a) (Signature of person who viewed body) Huntington Williams, M.D.
(b) 1948 (Date viewed by registrar)
VS 151

MEDICAL CERTIFICATION

A

20. DATE OF DEATH October 5 1948, at 11:15 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis
Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. L. Fialkowski M.D.
Medical Examiner.
Date signed 10-6-48

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667400 Hal 5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667400 Registered No. 46 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County Somerset
(c) City or town Crisfield (If outside city or town limits, write RURAL and give town)
(d) Street No. Cove St (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mamie Hickman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Herman
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 5-27-86

8. AGE: Years 62 | Months 4 | Days 10 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edward Monball
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 (month) 8 (day) 48 (year)
(c) Cemetery or crematory Crisfield
Location Crisfield Maryland

18 (a) Funeral director H. Harvy Bradshaw
(b) Address Crisfield, Maryland

19 OCT 6 - 1948 (Date rec'd by registrar) Registrar for Allegany Co.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6 1948, at 12:15 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20 1948 to 10-6 1948, and that I last saw her alive on 10-6 1948.

Immediate cause of death: Intestinal Obstruction — Duration

Due to Generalized concinomatosis

Due to Carcinoma pistonal

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/25/48

Major findings of operation: generalized carcinomatosis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature John Hazlett
Address John Hopkins Hospital Date signed 10/6/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G67401 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 211 Pearl St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto City

(c) City or town Balto City (If outside city or town limits, write RURAL and give town)

(d) Street No. 211 Pearl St (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Rev Joshua Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mamie Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER

12. Name Joshua Williams

13. Birthplace Maryland

MOTHER

14. Maiden Name Sarah ?

15. Birthplace Maryland

16 (a) Informant Mamie Williams

(b) Address 211 Pearl St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto City

18 (a) Funeral director Wm A Jackson

(b) Address 916 Penna ave

19 (a) (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5 1948, at 10:32 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1948 to 10/5 1948, and that I last saw him alive on 10/4 1948.

Immediate cause of death Lobar Pneumonia — Duration 10 days

Due to

Due to

Other Conditions Systemic disease Heart Disease (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm Garner, M.D.

Address 213 Cornyn St Date signed 10/6/48

061 6-D

VS 150

G67402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

G67402 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Wheeling
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOGE GEORGE — GEORGE T. HOGE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Anna Rauschenberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1884

8. AGE: Years	Months	Days	If less than one day
64	7	15	14 hr. min.

9. Birthplace Wheeling W. Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William V. Hoge
13. Birthplace W. Va.

MOTHER
14. Maiden Name Virginia Hylund
15. Birthplace W. Va.

16 (a) Informant Mr. George T. Hoge Jr
(b) Address Wheeling, W. Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-6-48 (month) (day) (year)

(c) Cemetery or crematory
Location Wheeling W. Va.

18 (a) Funeral director Wm. J. Tuchner & Sons
(b) Address 1101 Eutaw Place Baltimore Md

19 (a) Date received by registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948, at 8:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1948, to 10-5 1948, and that I last saw him alive on 10-5 1948.

Immediate cause of death Pulmonary embolism post operative

Due to Ca thyroid Sigmoid Colon

Due to Ca of Urinary Bladder with Cerebral Metastasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation October 3 1948

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Boltenger M. D.
Address Sinai Hospital Date signed 10/6/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67403

IS-122851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67403 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 80 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2553 Flora Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Hammond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Apr. 25, 1857

8. AGE: Years	Months	Days	If less than one day
91	5	9	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Hammond
13. Birthplace Md.

MOTHER
14. Maiden Name Annie?
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (b) Date thereof 10/9/48
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory mt Auburn
Location md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Presstman St

19 (a) OCT 6 - 1948 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 152

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-4- 19 48, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10-48 to 10-4 19 48
and that I last saw him alive on 10-4- 19 48

Immediate cause of death Bronchial Pneumonia — Duration 7 days.

Due to

Due to

Other Conditions Arteriosclerotic heart disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Arteriosclerotic gangrene foot Lt.

of autopsy: Evidence of pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman Coll, M.D.
M. D.

Address 714 Eastern Ave Date signed 10-5-48

X

G67304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. (illegible)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Carey Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN W. GROSS, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1928

8. AGE: Years	Months	Days	If less than one day
20	-	5	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John W. Gross, Sr.
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Anna James Gross
15. Birthplace Balto., Md.

16 (a) Informant Sophia Burley
(b) Address 222 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 7, 1948. (month) (day) (year)

(c) Cemetery or crematory Balto. National

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Fulton Ave. Carrington Williams, Md

19 (a) OCT 6 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1948. at 5:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet-wound of left chest and abdomen.
Atelectasis of left lung

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 10-2-48 at Approx. 11:30 P. M.
(b) Where did injury occur? Carrollton Avenue and Mulberry Street
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Firearms

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10-4-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67405

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95c

G67405 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 Asquith St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Asquith St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Coe.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife Jefferson Coe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) September 1, 1851

8. AGE: Years	Months	Days	If less than one day
97	1	3	hr. min.

9. Birthplace Accomac Co., Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Abraham Glenn.
13. Birthplace Va.

MOTHER
14. Maiden Name Mary
15 Birthplace Va.

16 (a) Informant A. M. E. Home.
(b) Address 112 Asquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7, 1948. (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mr. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) Date received 1948 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1948, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1948, to Oct 4 1948, and that I last saw h[illegible] alive on Oct 3 1948

Immediate cause of death, Carcinoma - Rheumatism & Hypertension

Duration 5 mos.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury
23. Signature W. Stewart M. D.
Address 632 W. Hamburg Date signed Oct 5

VS 150

- correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G67306 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1197 N. Fulton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 None
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1197 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? No Yes or No)
If yes, name country

3 (a) FULL NAME Priscella Thompson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C.	married

6 (b) Name of husband or wife Henry Thompson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 1, 1892

8. AGE: Years	Months	Days	If less than one day
56	5	3	hr. min.

9. Birthplace Dudley, N.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Cox
13. Birthplace N.C.

MOTHER
14. Maiden Name Sarah
15 Birthplace N.C.

16 (a) Informant Irma Scott.
(b) Address 1197 N. Fulton Ave

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof October 6, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Goldsboro, N.C.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) 1948 (b) (Date rec'd by registrar) Registrar

Burington Williams, Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-4-1948 at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29-1948 to 10-4-1948.
and that I last saw her alive on 10-3-1948.

Immediate cause of death Cerebral hemorrhage — Duration 6 days

Due to

Due to

Other Conditions Hypertension and arteriosclerosis — months

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank L. Saunders M D
Address 029 N. Stricker Date signed 10-4-48

VS 150

Care of age is especially important. Physicians: please write the causes of death clearly and legibly.

G67307 48-21454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1581

G67307 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 Eagle st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gary Howard Rozzell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 5, 1940

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Rozzell
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Jessie Rogers
15. Birthplace Baltimore, Md.

16 (a) Informant Jessie Rozzell
(b) Address 1832 Eagle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 6, 1940 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) 1940 (Date received by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1940, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death	Duration
Respiratory failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. J. Cooper M. D.
Address 2 S 9th. Carey St Date signed 10-5-40

667408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9-7

Registered No. 667408

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(g) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2333 Eastern Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DORA M. WARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife George Ward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 24, 1879

8. AGE: Years 68 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business Home

FATHER
12. Name Machael Schultz
13. Birthplace Poland

MOTHER
14. Maiden Name Dora (Unknown)
15. Birthplace Poland

16 (a) Informant Thomas Ward
(b) Address 2333 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 6800 Eastern Avenue

18 (a) Funeral director LILLY & ZEILER, INC.
(b) Address 403 S. Wolfe St. Balto. 31.

19 (a) (Date received by registrar) (b)

OCT 6 - 1948

VS 151

Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948, 10:10A M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Williams M.D.
Medical Examiner.
Date signed 10-5-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BC-4P-18865
667409

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

154 Registered No. 667409

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RUR and name town)
(d) Street No. 821 Chuna Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Infant Baby Boy Spence
3 (b) If veteran, name war D. | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 30 48

8. AGE: Years	Months	Days	If less than one day: hr.	min.
	1	335		

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jerome H Spence
13. Birthplace Balto Md

MOTHER
14. Maiden Name Grace A Young
15. Birthplace Howard County

16 (a) Informant Jerome H Spence
(b) Address 821 Union St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemt
Location A A Co Md
18 (a) Funeral director Isaiah L Brown Son
(b) Address 16 W Montgomery St
19 (a) Date received Oct 8 1948 (Local registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-4 1948, at 6 04 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1948, to 10-4 1948, and that I last saw him alive on 10-4 1948.

Immediate cause of death Respiratory failure

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature J J Hreden Jr M. D.
Address Univ. Hosp Date signed 10-4-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G67410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G67410
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd & Herring Run
(c) Hospital or institution:
Sydenham Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Bond St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jerome Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 - 12 - 33

8. AGE: Years	Months	Days	If less than one day
15	4	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER	12. Name Sam Eaton
	13. Birthplace Littleton, N.C.
MOTHER	14. Maiden Name Nora Johnson
	15. Birthplace Littleton, N.C.

16 (a) Informant mother
(b) Address 1127 Bond St

17 (a) Removal (b) Date thereof 10/6/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Littleton N.C.

18 (a) Funeral director Mrs. Ross & Ellwood Dy
(b) Address 1129 N. Carlton St

OCT 6 1948
(Date rec'd by registrar) (b) Registrar

Carlington Hollingsworth

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 5 1948, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9 28 1948, to 10 5 1948, and that I last saw him alive on 10 4 1948.

Immediate cause of death Myocardial Degeneration

	Duration
Due to	
Due to	
Other Conditions Nephritis, Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. A. Carter M. D.
Address Sydenham Hosp Date signed 10 5 48

Certificate of death must be filed with REGISTRAR WITHIN FIVE DAYS after death. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Correct Name
Benjamin Franklin Harrell

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66711

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Balto.~~ Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Regester Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME B. Frank Harrell Benjamin Franklin Harrell

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: ?

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth M. Harrell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 9, 1881

8. AGE: Years 66 | Months 10 | Days 25 | If less than one day: hr. min.

9. Birthplace: Cherry Lake Florida
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Marcus I. Harrell
13. Birthplace: Florida

MOTHER
14. Maiden Name: Missouri Coffee
15. Birthplace: Cherry Lake, Florida

16 (a) Informant: Mrs. Charles R. Mueller
(b) Address: 614 Kingston Rd. Balto. 12.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/48 (month) (day) (year)
(c) Cemetery or crematory: Moreland Memorial
Location: Balto. Co. Md.

18 (a) Funeral director: Wm. J. Tickner & Sons, Inc.
(b) Address: North & Pa. Aves. Balto. 17.

19 10/6/48 (Date registered by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4th 1948, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to he death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Neff M.D.
Medical Examiner.
Date signed Oct 4, 1948

VS 191

66712 St - 48 - 1325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. 66712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor + Dukeland
(c) Hospital or institution: West Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 452 Hommel St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Francis Marrow

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/10/48

8. AGE: Years	Months	Days	If less than one day
		1	hr. 35 min.

9. Birthplace West Balto General Hosp (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Marrow
13. Birthplace Italy

MOTHER
14. Maiden Name Esther Farchione
15. Birthplace Milwaukee Wisc

16 (a) Informant Mrs Esther Marrow
(b) Address 452 Hommel St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School SEP 30 1948 Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) OCT 6 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11/48 19 . at 11 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10/ 1948 to 9/11/ 1948, and that I last saw h[illegible] alive on 9/11 1948.

Immediate cause of death Atra - cranial Hemorrhage, massive atelectasis, bilateral

Duration 1 day 1 day

Due to causes unknown.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Intracranial Hemorrhage - atelectasis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P A Young
Address West Balto Gen Hosp Date signed 9/12 D.

VS 150

Type or write with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

667413 ✓

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto. city
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Chas St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country. Canada

3 (a) FULL NAME Leroy King

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Bl	Divorced

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
60			..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Painter

11 Industry or business .....

FATHER
12. Name John King
13. Birthplace Md.

MOTHER
14. Maiden Name .....
15 Birthplace .....

16 (a) Informant Wm Huber
(b) Address Wheeling W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6th 1948 (month) (day) (year)

(c) Cemetery or crematory .....
Location Wheeling W. Va.

18 (a) Funeral director Leo G. Cook
(b) Address 2018 N Patterson Park Ave

19 (a) 10/5/48 (Date rec'd by) (b) Washington Nationals, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1 1948, at 6 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1948 to 10-1 1948 and that I last saw him alive on 10-1 1948

Immediate cause of death Coronary occlusion — Duration .....

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Brian O'Donnell, Jr. M.D.
Address Mercy Hosp Date signed 10-2-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

67414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162 C

G67414 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2531 St. Paul Street
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) ***
(e) Length of stay in Baltimore (yrs., mos., or days) 72 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County *******
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 St. Paul St. (If rural give location)
(e) Citizen of foreign country? ******* (Yes or No) If yes, name country *********

3 (a) **FULL NAME** Lucetta Moore Scopinich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife A. Antonio Scopinich
6 (c) If alive, give age ** years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1852

8. AGE: Years	Months	Days	If less than one day
95	11	1	** hr. ** min.

9. Birthplace Bermuda
(Town, county, and state)
10. Usual Occupation None
11. Industry or business *******

FATHER
12. Name Isaac Peck Cooper
13. Birthplace Bermuda

MOTHER
14. Maiden Name Elizabeth Jane Kempold
15. Birthplace Bermuda

16 (a) Informant Antonio James Scopinich
(b) Address 3947 Cloverhill Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Ko. W. Mears and Son
(b) Address 800 N. Calvert Street

19 (a) OCT 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Oct 5 1948. and that I last saw her alive on Oct 5 1948.

Immediate cause of death Coronary Thrombosis
Due to Senility
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 4 Mo.

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Clarkson M.D.
Address 2806 Mount Royal Ave. Date signed 10/6/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667415

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wayne & Lukeland Aves.
(c) Hospital or institution:
West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 DA
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Berwick ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth Zeller

3 (b) If veteran, name war ****

3 (c) Social Security Account No. ****

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife Joseph Zeller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 1, 1884

8. AGE: Years	Months	Days	If less than one day
64	1	4	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Henry Schneck
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Gottschalk
15. Birthplace Baltimore, Maryland

16 (a) Informant Lolores Zeller
(b) Address 2912 Berwick Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/6/48 (month) (day) (year)
(c) Cemetery or crematory Arlington, National
Location Arlington, Va.

18 (a) Funeral director R. W. Meary & Son
(b) Address 805 N. Calvert Street

19 (a) OCT 6 - 1948 (Date rec'd by registrar) **(b)** Huntington Ave Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1948 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 1948 to Oct 5 1948, and that I last saw h[illegible] alive on Oct 5 1948.

Immediate cause of death Cardiorespiratory arrest — Duration: 10 yrs.

Due to Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions Coronary Artery Disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Lewis Silverstein M. D.
Address West Balto Gen Hosp Date signed 10/6/48

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. 667416

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3707 Beehler Avenue
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Maryland
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Ida Hassid

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Nata Julius

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1901

8. AGE: Years	Months	Days	If less than one day
47	5	24	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation —

11. Industry or business Housewife

FATHER
12. Name David Levin
13. Birthplace Russia

MOTHER
14. Maiden Name Lena Chickoff
15. Birthplace Russia

16 (a) Informant Mrs. Goldie Wolf
(b) Address 3707 Beehler Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 7 48 (month) (day) (year)
(c) Cemetery or crematory Chevra Kadisha Corp.
Location Rosedale, Hamilton Avenue

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 124-26 W. North Avenue

19 (a) OCT 7 - 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1948, at 9:12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1945, to Oct 6, 1948.
and that I last saw her alive on Oct. 6 1948.

Immediate cause of death Respiratory failure

Due to Renal Debility

Due to Carcinomatosis (Ovarian origin?)

Other Conditions Pyelitis & Intestinal Obstruction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert C. Hunter, M.D.
(M.D.)
Address University Hosp. Date signed 10-7-48

VS 150

667417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. 667417

Type or print plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Levindale Home Belvidere ave
(d) Length of stay in hospital or inst. (yrs., mos.) or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3916 Park Heights ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Sandler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: W.
6 (b) Name of husband or wife: Lota Fannie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1878
8. AGE: Years 70 | Months | Days | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Morris Sandler
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Meyer Sandler
(b) Address 2815 Violet ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7/48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Blvd
Location Washington Blvd
18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave
19 (a) OCT 7 - 1948 (Date rec'd by registrar) Huntington Philadelphia Pa. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6th 1948 at 9.54 A M
21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1948 to October 6 1948, and that I last saw him alive on October 6 1948

	Duration
Immediate cause of death: Cerebral thrombosis	
Due to: Cerebral arteriosclerosis	
Due to:	
Other Conditions: Status post left side hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Jerome J. Blumberg M. D.
Address Levindale Home Date signed 10/6/48

VS 150

667418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667418

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St
(c) Hospital or institution:
Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 W. Franklin St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LUCY HINES

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4/5/1883

8. AGE: Years 65 | Months 5 | Days 29 | If less than one y: hr. min.

9. Birthplace Stoney Creek, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alonzo Freeman
13. Birthplace Va

MOTHER
14. Maiden Name Lucy J. Freeman
15. Birthplace Petersburg, Va.

16 (a) Informant Bessie Brown(D)
(b) Address 1533 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 Carrellton Ave

19 (a) OCT 7 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4/48 19 , at 10:00 A

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1948 to Oct 4 1948, and that I last saw him alive on Oct 2 1948.

Immediate cause of death: Myocardial Infarction — Duration: unknown

Due to (b) Arteriosclerosis — Duration: unknown

Due to (c)

Other Conditions

(Include) regnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allen Coleman
Address 4611 Edmondson Date signed 10/7/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

667419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 667419 Registered No. 556

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gatow & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Dorsey Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Zuck
3 (b) If veteran, name war
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	married

6 (b) Name of husband or wife Thelma D Zuck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 22, 1888

8. AGE: Years	Months	Days	If less than one day
60	0	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Mt. Clare Balto. Ohio RR

FATHER
12. Name John A. Zuck
13. Birthplace Pittsburgh, Pa.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Walter Zuck
(b) Address Dorsey, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-48 (month) (day) (year)
(c) Cemetery or crematory Zion
Location Dorsey Md.

18 (a) Funeral director Dewitt Donaldson
(b) Address Laurel Maryland

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1948, at 8 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28/ 1948 to 10/5 1948. and that I last saw him alive on 10/5/ 1948.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	
Due to TERMINAL UREMIA	
Due to MULTIPLE MYELOMA	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9/14/48 Endothelioma
Major findings of operation: MYELOMA OF BONE -
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or Homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Shaw
Address St. Agnes Hosp. Date signed 10/6/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128

Registered No. 667420

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED.
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1048 Pennsylvania Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUGENIA WHITNEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife William P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1910

8. AGE: Years	Months	Days	If less than one day
38	5	9	hr. min.

9. Birthplace Brunswick, Georgia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Eugene Wilson
13. Birthplace Americus, Georgia

MOTHER
14. Maiden Name Mamie L. Hall
15. Birthplace Americus, Georgia

16 (a) Informant Holland Funeral Home
(b) Address 1631 Druid Hill Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location Baltimore Co. Md.

18 (a) Funeral director Holland Funeral Home
(b) Address 1631 Druid Hill Ave.

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1948 at 8:10 P. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.

Date signed 10-6-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667421

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

667421 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rosa Louise Andrews

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Warren H. Andrews
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Sept. 14, 1881

8. AGE: Years	Months	Days	If less than one day
67		21	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph A. Albrecht
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Hess
15. Birthplace Germany

16 (a) Informant Miss Lillie E. Albrecht
(b) Address 1710 N. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Md.

18 (a) Funeral director Albert L. Feldt Jr.
(b) Address 1606 N. Chester Street

19 (a) OCT 7 - 1948 (Date rec'd by registrar) Huntington for Nathaniel, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1948, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from October 3, 1948, to October 5, 1948, and that I last saw her alive on October 5, 1948

Immediate cause of death Respiratory failure — Duration

Due to Lobar pneumonia

Due to

Other Conditions Cerebro-vascular Accident
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bilateral pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank W. Baker, Jr. M. D.
Address St. Joseph's Hospital Date signed Oct 5-48

X

VS 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. G67122

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 26-
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH BERNINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Andrew Berninger
6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) May 10, 1870

8. AGE: Years	Months	Days	If less than one day
78	4	24	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Hollar
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Germany

16 (a) Informant Andrew Berninger
(b) Address 3908 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7, 1948 (month) (day) (year)
(c) Cemetery or crematory Trinity Cemetary
Location

18 (a) Funeral director E. Sanders & Sons
(b) Address N. Ave. & Broadway

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) Interrington Nathanson (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5, 1948, at 10:15 M

21. I certify that I took charge of the remains described above, held an Partial Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of gall-bladder with metastases to liver

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/5/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D 674423

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 674423

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 No Smallwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Duskin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Hattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 72 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Morris
13. Birthplace Russia

MOTHER 14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Frank Duskin
(b) Address 1814 No Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-48 (month) (day) (year)
(c) Cemetery or crematory
Location Nethow Herring Run

18 (a) Funeral director Jack Lewis Inc
(b) Address 2460 Eutaw Place

19 OCT 7 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7-48 19 at 12 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 19 48 to Oct. 7 19 48. and that I last saw h/ alive on Oct 6 19 48

Immediate cause of death: Coronary thrombosis - Duration 3 wks.

Due to Arteriosclerosis

Due to

Other Conditions Diabetes Mellitus 10 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S.I. Smith.

Address 1223 E. North Date signed 10/7/48 M.D.

VS 150

940

1674 24 H2H-2

BALTIMORE CITY HEALTH DEPARTMENT X ✓ Registered No. 1674 24

CERTIFICATE OF DEATH

1 STE

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ontario (b) County
(c) City or town Toronto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1344 Avenue Road (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Canada

3 (a) FULL NAME Patrick Hugh Love.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9 21 48

8. AGE: Years | Months 2 | Days 7 | If less than one day hr. min

9. Birthplace Canada (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Denis Love ?
13. Birthplace

MOTHER
14. Maiden Name Doris ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Hart Interfaith

18 (a) Funeral director
(b) Address

19 OCT 7 - 1948 (Date rec'd by Registrar) (b) Huntington Woods Mich. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1948 to 10-6 1948 and that I last saw him alive on 10-6 1948

Immediate cause of death	Duration
Pulmonary Edema	
Due to Cardiac Decompensation	
Due to Congenital Heart Lesion	
Other Conditions Decomposition of Vessels	

(Include pregnancy within 3 months of death)

Date of operation Oct 5, 1948

Major findings of operation: Decomposition of Vessels

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D A Casalis M.D.
(Attending physician or coroner) Johns Hopkins Hospital Date signed Oct 6 '48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67425

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline
(c) Hospital, Institution:
St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1947 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mrs. Sue Ward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife William F. Ward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1902

8. AGE: Years 46 | Months 6 5 | Days 1 | If less than one day hr. min.

9. Birthplace Toronto, Canada
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Annie Wamsley
15. Birthplace England

16 (a) Informant William F. Ward
(b) Address 2800 Clearview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Taylor Ave

18 (a) Funeral director Howard H. Bligh Jr.
(b) Address 6009 Dalford Road

OCT 7 - 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1948, at 6:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4, 1948 to Oct. 5, 1948.
and that I last saw her alive on Oct. 5, 1948.

Immediate cause of death: massive gastro-intestinal hemorrhage — Duration

Due to: Penetrating gastric ulcer.

Due to:

Other Conditions: Central nervous system syphilis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Gastro-intestinal hemorrhage

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Wm. H. Rodgers M.D.
Address St. Joseph's Hospital Date signed 10-5-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67426

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Randall Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Nelson Lee Tinsley

3 (b) If veteran, name war: World #1

3 (c) Social Security Account No. —

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lavina F. Tinsley

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec. 28-1885

8. AGE: Years 62 | Months 9 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Draftsman

11. Industry or business State of Maryland

FATHER 12. Name Frank Tinsley

13. Birthplace Maryland

MOTHER 14. Maiden Name Catherine Dennick

15. Birthplace Maryland

16 (a) Informant Mrs. Lavina F. Tinsley

(b) Address 2 Randall Ave. Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 8-1948 (month, day, year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) OCT 7 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1948, at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ____ at ____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? ____ While at work? ____

(d) Means of injury

23. Signature Adrian G Skyrock M.D. Medical Examiner

Date signed Oct 5th 1948

X

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Order 6

667427

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 128

667427
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 828 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Zaniewski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-29-08

8. AGE: Years	Months	Days	If less than one day
40	2	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Bar Tender
11. Industry or business

PATHER
12. Name Stanislaw Zaniewski
13. Birthplace Poland

MOTHER
14. Maiden Name Sophie Kasmaczewska
15. Birthplace Poland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9/48 (month), (day), (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore
18 (a) Funeral director Fred W Ozozowski
(b) Address 1938 Eastern Ave
19 (a) OCT 7 1948 Lexington Williamsport
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2 1948 to 10-5 1948, and that I last saw him alive on 10-5 1948.

Immediate cause of death Spontaneous tension pneumothorax - right side. — Duration 4d.
Due to Pulmonary tuberculosis - active
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work?)
(e) Means of injury
23. Signature [illegible] Jackson
Address [illegible] Date signed 10/5/48

VS 150

667428 46-2925

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 667428

CERTIFICATE OF DEATH 15E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19
(c) Hospital or institution: Mercy Hospital, Balto. Md
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 8
(e) Length of stay in Baltimore (~~yrs., mos., or~~ days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 Fleet St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Edward ~~Galcyn~~ Golczynski

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 29, 1948

8. AGE: Years	Months	Days	If less than one day
—	—	8	— hr. — min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER 12. Name Charles Golczynski

13. Birthplace New Jersey

MOTHER 14. Maiden Name Stephanie Malanowski

15. Birthplace

16 (a) Informant Charles Golczynski

(b) Address 1918 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8/48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Fred W Ozarowski

(b) Address 1930 Eastern Ave

19 Oct 7 1948 (Date rec'd by Registrar) Huntington Indiana Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1948 at 6:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1948 to Oct 6 1948, and that I last saw him alive on Oct 6 1948

Immediate cause of death Cardiac Failure

Due to Congenital Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature A. M. Bacon Jr. M. D.

Address Mercy Hospital Date signed 10-6-48

VS 150

G67423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8-2a

G67429 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3129 Guilford Ave
(c) Hospital or institution: 1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3129 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry A. Tregor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Nora A. Tregor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17 1883

8. AGE: Years	Months	Days	If less than one day
64	11	19	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Marcus Tregor
13. Birthplace Germany

MOTHER
14. Maiden Name Rosalie (Markuson)
15. Birthplace Germany

16 (a) Informant Mrs. Nora A. Tregor
(b) Address 3129 Guilford Ave

17 (a) Cremation (~~Burial~~, cremation, ~~or removal~~) (b) Date thereof 10/8/48 (month) (day) (year)
(c) ~~Cemetery or~~ crematory Green Mount
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 7 - 1948 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6th 1948, at 2:30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5-1948. to 10-6-1948 and that I last saw him alive on 10-6-1948.

	Duration
Immediate cause of death: Cerebral Hemorrhage Rt.	12 hrs.
Due to: Generalized Arteriosclerosis	
Due to: Lt. Hemiplegia	12 hrs
Other Conditions: Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, etc.)
(e) Means of injury

23. Signature [illegible] M. D.
Address Calvert & 30th St. Date signed 10-7-48

VS 150

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667430
391692

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667430

55E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Kerens (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Columbus Kerens

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Grace Kerens
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 1-27-90

8. AGE: Years	Months	Days	If less than one day
58	8	11 10	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Columbus Kerens
13. Birthplace W. Va.

MOTHER
14. Maiden Name Jennie Carr
15. Birthplace W. Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10-7-48 (month) (day) (year)
(c) Cemetery or crematory Elkins
Location Elkins W Va

18 (a) Funeral director Pullman & Kee
(b) Address 1219 Druid Pl

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1948, at 10 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 - 4 1948, to 10-6 1948, and that I last saw him alive on 10-6 1948.

Immediate cause of death	Duration
(a) Myocardial Infarction, Massive	6 hours
Due to (b) Coronary Thrombosis	6 hours
Due to (c)	
Other Conditions Mixed Tumor of Parotid Gland	

(Include pregnancy within 3 months of death)

Date of operation 10/5/48
Major findings of operation: Mixed Tumor of Parotid Gland
of autopsy: Coronary Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [illegible]
Address Johns Hopkins Hospital Date signed 10/6/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

667431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667431

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3409 Mayfield Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Mayfield Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles E. Schmidt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna K. Richter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1886

8. AGE: Years	Months	Days	If less than one day
62	5	13	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Pipe Fitter
11. Industry or business Standard Oil Co.

FATHER
12. Name John Schmidt
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary M. Winteroth
15 Birthplace Tenn.

16 (a) Informant Anna K. Schmidt
(b) Address 3409 Mayfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery or crematory Schwartz's
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) OCT 7 1948 (Date received by registrar) Interment for Williams Undertaking Co. Balto. Co.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 19 48 at Sinai M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 19 41 to Oct 4 19 48, and that I last saw him alive on Oct 4 19 48

Immediate cause of death: Coronary Thrombosis — Duration 4 years ?
Due to Cardio-Vascular Typhus
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George S. Bayley M.D.
Date signed 10/7/48 M.D.

VS 150

Physicians: please write the causes of death clearly and legibly. Information is especially important. Be sure that all necessary entries are correctly supplied. The correct age is especially important.

0673332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 0673332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st Street
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 1 mo. 11
(e) Length of stay in Baltimore (yrs., mos., or days) as "d"

2. USUAL RESIDENCE OF DECEASED:
(a) State Miss (b) County
(c) City or town Phoba
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEE, ROBERT FRANKLIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	s

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 19, 1904

8. AGE: Years	Months	Days	If less than one day
43	11	14	hr. min.

9. Birthplace Phoba, Miss (Town, county, and state)
10. Usual Occupation painter
11. Industry or business -

FATHER
12. Name George Franklin Lee
13. Birthplace Phoba, Miss

MOTHER
14. Maiden Name Ella Shootsman
15. Birthplace Miss

16 (a) Informant Records
(b) Address U S Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-7-48 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Lyman Ave

18 (a) Funeral director Chas B Woodson Jr
(b) Address 402 E. 25th St

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) Burial Permit Issued, Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1948, at 12:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22, 1947 to Oct. 3, 1948 and that I last saw h im alive on Oct. 3, 1948

Immediate cause of death	Duration
1-Carcinoma of penis, post-operative state, with metastases to regional	
Due to and periaortic nodes	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson M. D.
Address Clinical Director Date signed 10-4-48

V S 150

To 67433

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 26383

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4425 Forest View Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4425 Forest View Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Duczar or Ducar

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife Eva Duczar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 1 1871

8. AGE: Years	Months	Days	If less than one day
77	6	4	hr. min.

9. Birthplace Hungary (town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name John Duczar
13. Birthplace Hungary

MOTHER
14. Maiden Name unknown
15. Birthplace Hungary

16 (a) Informant Elisabeth Duczar
(b) Address 4425 Forest View Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Blair Road

18 (a) Funeral director Marie E. Fiskowski
(b) Address 4000 S. Kenwood Ave

19 (a) OCT 7 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1948 at 11 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2. 1948 to Oct 5 1948. and that I last saw h alive on Oct 4 1948.

Immediate cause of death Pulmonary Failure — Duration 3 days

Due to Chr. Myocarditis

Due to Hypostatic Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Standing M. D.
Address 350 S. Bel... Ave. Date signed 10/7/48

VS 150

6674:34

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 6674:34

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Ashburton Nursing Home
(b) Street address 3520 Hilton
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2752 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret P. Legg

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Nicholas N. Legg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1863

8. AGE: Years	Months	Days	If less than one day
84	10	1	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Daniel Scanlon
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Eleanora A. Altwater
(b) Address 2752 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8th 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Mrs. John H. Teufel & Son
(b) Address 5316 Edmondson Ave

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) Huntington Williamsport Pa

VE 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5, 1948, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1948 to Oct. 5, 1948. and that I last saw h alive on Sept. 29, 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	7
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor J. Levy
Address 232 Eastern Place Date signed 10/7/48

674335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30a

674335 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 N. Stricker
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 N. Stricker
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Edward Norris

3 (b) If veteran, name war — W.W.I.

3 (c) Social Security Account No. 705-05-8172

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Div.

6 (b) Name of husband or wife Nettie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/3/1890

8. AGE: Years 58 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace Md Baltimore City.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name Thos. P. Norris

13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Ida Green

15. Birthplace Md

16 (a) Informant Wm Norris

(b) Address 900 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/48 (month) (day) (year)

(c) Cemetery or crematory Balto. Nat.

Location Md.

18 (a) Funeral director Geo. B. Kelson

(b) Address 1305 Pleasant St

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) Huntington for Williams Mc Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4th 1948, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1947 to Oct 4 1948.
and that I last saw him alive on Oct 4 1948.

Immediate cause of death Cardiac Dilatation
Due to Acute Myocarditis
Due to Hypertension

Duration 3 years

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. B. Tongue M. D.
Address 926 N. Bremerton Date signed 10-6-48

VS 3

67436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 67436

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2363 Dennore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5303 Dennore ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/5/1893

8. AGE: Years 55 | Months 2 | Days - | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation H. Wife

11. Industry or business

FATHER 12. Name

FATHER 13. Birthplace

MOTHER 14. Maiden Name Josephine Stuffin

MOTHER 15. Birthplace Md

16 (a) Informant Rev Richard Jackson

(b) Address 5303 Dennore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Geo. B. Kelson

(b) Address 1303 Pennsylvania Ave

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 Oct. 1948, at 9:10 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Wm. H. Kammer M.D. Medical Examiner.

Date signed 6-7-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 23673-37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINAI
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town HALETHORPE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4115 OLD WASHINGTON BLVD (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SAMUEL HELWIG

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-22-7455

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MARJORIE HELWIG
6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr) 12-21-22

8. AGE: Years	Months	Days	If less than one day
25	9	16	15 hr. min.

9. Birthplace BALTIMORE COUNTY, MD. (Town, county, and state)
10. Usual Occupation MASON
11. Industry or business BUILDING

FATHER
12. Name HARRY HELWIG
13. Birthplace BALTO. COUNTY MD

MOTHER
14. Maiden Name CATHERINE LISNER
15. Birthplace BALTO. MD.

16 (a) Informant MARJORIE HELWIG
(b) Address 4115 OLD WASHINGTON BLVD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-9-48 (month) (day) (year)
(c) Cemetery or crematory MEDOWRIDGE CEM.
Location WASHINGTON BLVD

18 (a) Funeral director Joseph T. Gontrum Jr.
(b) Address 1348 Shelphen Spring Rd.

19 OCT 7 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5 1948 at 4:00 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/26 1948 to 10/5 1948 and that I last saw him alive on 10/5 1948.

Immediate cause of death Rheumatic Heart Disease - active — Duration

Due to

Due to

Other Conditions Cardiac Cirrhosis Uremia (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard Hepler M.D.
Address Sinai Hospital Date signed 10/5/48

VS 150

G67438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G67438 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline
(c) Hospital ~~or Institution~~ St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 Gibbons Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No) If yes, name country

3 (a) FULL NAME Mr. Oliver R. Nicklas

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No. 154-07-3926

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife. Irene Josephine Nicklas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 1, 1897

8. AGE: Years	Months	Days	If less than one day: hr.	min.
51	2	5		

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation ~~None~~ Hotel Manager
11. Industry or business

FATHER
12. Name Andrew Nicklas
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Neva Rothert
15. Birthplace Baltimore Md.

16 (a) Informant: Irene Nicklas
(b) Address 3312 Gibbons Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Reistertown Road

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 South Wolfe St.

19 (a) OCT 1948 (Date rec'd by registrar) (b) Huntington / Pikesville Md.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1948, at 2:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29, 1948 to Oct. 6, 1948 and that I last saw him alive on Oct. 6, 1948

Immediate cause of death	Duration
Respiratory Failure	
Due to Hypertensive-Cardio-Vascular Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank W. Balough M. D.
Address St. Joseph's Hospital Signed 10-6-48

667439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

667439 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Boarman Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS MARIE LONG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced ------

6 (b) Name of husband or wife ----

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1941

8. AGE: Years 7 | Months 0 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Nashville, Tenn (Town, county, and state)

10. Usual Occupation ---

11. Industry or business --

FATHER
12. Name James Edward Long
13. Birthplace Ashland City, Tenn.

MOTHER
14. Maiden Name Essie Dubree
15. Birthplace Tenn.

16 (a) Informant James E. Long
(b) Address 2901 Boarman Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9, 1948 (month)
(c) Cemetery or crematory Govans Presbyterian
Location Baltimore, Maryland

18 (a) Funeral director Ellsworth Amadost
(b) Address 3911 Liberty Heights

19 (a) OCT 7 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1948, at 6:12 P. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to

Other Conditions (Include pregnancy within three months of death)

22. If an external cause was primary ☒ or secondary ☐ cause of death, fill in the following:
(a) Date of injury 10-6-48 5:55 P. M.
(b) Where did injury occur? Reisterstown Road and Boarman Avenue
(c) Did injury occur at home, on farm, in industrial place, in public place? Public (What was victim doing?) Ped struck by auto. No
(d) Means of injury

23. Signature Earl L Royston M.D. (Medical Examiner)
Date signed 10-7-48

VS 151

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

667440

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

166

667440 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Argyle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM (N. M. I.) JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1905

8. AGE: Years 42 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace New Orleans, La. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace New Orleans

MOTHER
14. Maiden Name Unknown
15. Birthplace New Orleans

16 (a) Informant: Octavia Davis
(b) Address 1623 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-48 (month) (day) (year)

(c) Cemetery or crematory
Location Baltimore National Cem.

18 (a) Funeral director A. Halsteadt
(b) Address 918 Druid Hill Ave.

19 (a) (b)
(Date rec'd by registrar) (Registrar)

OCT 7 - 1948

Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1948 at 4.05p M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized Peritonitis

Due to Bullet wound of Abdomen

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-3-48 at approx. 5.30 p. M.
(b) Where did injury occur? 1623 Argyle Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury firearms

23. Signature Earl R. Boyer M.D.
(Medical Examiner)
Date signed October 5, 1948

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67441

BC-48-20168

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

56E

G67441
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Stockton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Christopher John Zaleski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 25, 1948

8. AGE: Years	Months	Days	If less than one day
		11	hr. min.

9. Birthplace Baltimore, Balt. Co., Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Stephen Zaleski
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Sarah Lipton
15. Birthplace North Carolina

16 (a) Informant Stephen Zaleski
(b) Address 1128 Stockton ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Balto. County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

OCT 7 - 1948 (Date rec'd by registrar) (b) Registrar

Interim for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1948 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2, 1948 to Oct. 6, 1948 and that I last saw him alive on Oct. 6, 1948.

	Duration
Immediate cause of death Intestinal Obstruction	4 days
Due to Post operative (for)	4 days
Due to Enterogenous cyst, cecum	11 days
Other Conditions Peritonitis generalized Bronchopneumonia (Include pregnancy within 3 months of death)	

Date of operation Oct. 2, 1948
Major findings of operation: Enterogenous cyst, cecum.
of autopsy: Peritonitis, bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed

VS 153

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67442

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

951 Reg. Dist. No.

67442

1. PLACE OF DEATH:
County 5707 WINNER AVE.
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5707 WINNER AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME BEATRICE Rose STEINACKER

3. (b) Social Security Number —

4. Sex: FEMALE
5. Color or race: WHITE
6. (a) Single, married, widowed, or divorced: WIDOWED
(b) Name of husband or wife: Edgar W. Steinacker
(c) If alive, give age years
Birth date of deceased (mo., day, yr.): 10-14-1887
7. AGE: Years 60 Months 11 Days 22 If less than one day hrs. min.
8. Birthplace Baltimore - Md (Town, county, and state)
9. Usual occupation House wife
10. Industry or business At Home
11. Name Robert I. Christie
12. Birthplace Maryland
13. Maiden name Harkins Mathias
14. Birthplace Maryland
15. Informant Edgar W. Steinacker - Son
Address 5914 Frederick Ave
Burial (Burial, cremation, or removal. Which?) Date thereof 10/8/48 (month) (day) (year)
Cemetery or crematory London Park
Location Baltimore Md.
16. Funeral director H. B. Wiltbank & Son
Address 1300 Eutaw Place 17
OCT 7 - 1948 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1948 at 12 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1946 to October 5, 1948
and that I last saw h.. alive on October 2 1948

Immediate cause of death — DURATION

Coronary Occlusion — 45 min

Due to Rheumatic Heart Disease — years (?)

Due to —

Other conditions Obesity

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:-
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Louis Adman M. D. or other
Address 1413 Reisterstown Rd Pikesville
Date signed Oct 5, 1948

667443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

667443 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2515 Fait Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2515 Fait Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Maryanna Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28 1866

8. AGE: Years	Months	Days	If less than one day
82	-	7	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Graff
13. Birthplace Germany

MOTHER
14. Maiden Name Linkenofen
15. Birthplace

16 (a) Informant Tekla Laniewski
(b) Address 2515 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9 1948 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cemetery
Location Dundalk Ave

18 (a) Funeral director John F. Duda
(b) Address 2829 Hudson St

19 OCT 7 1948 (Date rec'd by Registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1948 at 7:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1948 to Oct 5 1948 and that I last saw h[illegible] alive on Oct 4 1948.

Immediate cause of death	Duration
(a) Arteriosclerosis	2 yrs.
(b) Chronic nephritis. Uremia	2 wks.
Due to (c) Bronchopneumonia	
Due to Decubitus ulcers.	1 mo.

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. A. Lyon M. D.
Address 432 S. Patterson Pk Date signed 10/7/48

VS 3

667441

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

667344 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 Oakhill ave. (If rural give location)
(e) Citizen of foreign country? No, (Yes or No)
If yes, name country

VOLLMAN

3 (a) FULL NAME Mrs. Emma I Smith

3 (b) If veteran, name war: no

3 (c) Social Security Account No. no

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife: Charles Justus Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16 1874

8. AGE: Years 73 | Months 9 | Days 20 | If less than one day, hr. min.

9. Birthplace Md (Balto.) (Town, county, and state)

10. Usual Occupation Home wife.

11. Industry or business

FATHER
12. Name John C. Vollman
13. Birthplace Germany

MOTHER
14. Maiden Name not known Rodeman
15. Birthplace Germany

16 (a) Informant Mr. Charles J. Smith
(b) Address 4011 Deepwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 7 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1948 at 10:20 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/3 1948 to 10/6 1948, and that I last saw him alive on 10/6 1948.

Immediate cause of death: Cardiac failure - Coronary Thrombosis -
Due to: Arteriosclerotic Heart Disease
Due to: Diabetes Mellitus
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D O Nuttle
Address Church Home Date signed 10/9/48 M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

667445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

667445 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Charles & 31st Street
(c) Hospital or institution:
The Homewood Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & 31st Sts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Mills Besoré

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Alpheus N. Besore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1875

8. AGE: Years 72 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Ezekiel Mills, Jr.
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary Virginia Porter
15. Birthplace Balto.

16 (a) Informant Mr. Charles Edwin Besore
(b) Address 6417 Blenheim Rd.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10/8/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

(c) Date received by registrar 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6th 1946, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Oct 1946, and that I last saw her alive on Oct 6th 1946.

Immediate cause of death Carcinoma of Stomach — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Helfrich

Address 5006 Roland Ave Balto 10

Date signed Oct 6th 1946

VS 150

667446

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

Registered No. 667446

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 E. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 E. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Hihn Thieme

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles H. Thieme

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): March 17, 1861

8. AGE: Years: 87 | Months: 6 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: J. Bernard Hihn
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary Rauch
15. Birthplace: Germany

16 (a) Informant: Mrs. Norma T. Roberts
(b) Address: 3822 Bonner Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/9/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. Tickner & Sons, Inc.
(b) Address: North & Pa. Aves. Balto. 17, Md.

OCT 7 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 6, 1948 at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to Oct 6 1948 and that I last saw h[illegible] alive on Oct 6 1948

Immediate cause of death: Cardiac insufficiency — Duration: 2 days
Due to: General Arteriosclerosis — Duration: 5 years
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury: WILBUR F. SHULMAN

23. Signature: Hallen F. Shulman M.D.
Address: 6 E. Biddle St. Date signed: 10/7/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS (50)

667447 ✓ 667447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 448

Registered No. .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2832 Waterview Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2832 Waterview Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Henry Sinclair

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Nioletta V. Sinclair
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 2, 1889

8. AGE: Years	Months	Days	If less than one day
59	8	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Cloth Sponger
11. Industry or business

FATHER
12. Name John Sinclair
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ogle
15. Birthplace Md.

16 (a) Informant Mrs. Oliver Fisher
(b) Address 2832 Waterview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Anne Arundel Co. Md.

18 (a) Funeral director Wm. J. Ticknor & Sons, Inc.
(b) Address North & Pa. Aves. Balto. 17, Md

OCT 7 1948 (Date rec'd by registrar) (b) Burton Phillips MD

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to October 1948 and that I last saw him alive on October 2 1948

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions Lymphogranuloma	

(Include pregnancy within 3 months of death)
Date of operation August 1948
Major findings of operation: Lymphogranuloma tumor of spleen
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris W. Steinberg M D
Address 410 N. Milton St Date signed Oct 7, 1948

VS 152

X

2 667448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667448

Registered No. 1248

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 36 S. Arlington Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 36 S. Arlington Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise A. Stout

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles O. Stout

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1878

8. AGE: Years	Months	Days	If less than one day
70		17	hr. min.

9. Birthplace Hanover, Pa. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER

12. Name William Dresher

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Mary Clouser

15. Birthplace Pa.

16 (a) Informant Charles O. Stout

(b) Address 36 S. Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)

(c) Cemetery or crematory Rest Haven

Location Hanover, Pa.

18 (a) Funeral director Frederick J. Cole

(b) Address 2000 Linsbard St

19 (a) OCT 7 1948 (b) Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 19 48 at 10:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to 10/6 1948 and that I last saw h[illegible] alive on 10/5 1948

Immediate cause of death

Due to Coronary Thrombosis & Embolus — Duration 8 mos

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Chas A Cahn M.D.

Address 2145 W Balto St Date signed 10/7/48

VS 150

3 667449

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667449 Registered No. 124 B

correct age is especially important. Physicians: please write the causes of death clearly and le

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: BON SECOURS HOSP
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) ~~State~~ Md. (b) County
(c) City or town BALTIMORE 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 N WHEELER AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MR. William CHARLES HAAS
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-01-4983

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
MALE	WHITE	Married

6 (b) Name of husband or wife MRS. ELVA HAAS
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) NOV. 23, 1908

8. AGE: Years	Months	Days	If less than one day
39	10	12	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation CHECKER
11. Industry or business A.P. WAREHOUSE

FATHER
12. Name HENRY HAAS
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name LAURA V. LYONS
15. Birthplace BALTIMORE, MD.

16 (a) Informant Mrs. Elva F. Haas
(b) Address 114 N. Wheeler ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-48 (month) (day) (year)
(c) Cemetery or crematory New National
Location Baltimore

18 (a) Funeral director Frederick H. Cole
(b) Address 1210 W. Lombard St. Baltimore, Md.

19 OCT 7 1948 (Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5, 1948 1948. at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1948. to 10/5 1948. and that I last saw him alive on 10/4 1948.

Immediate cause of death Heart Failure — Duration

Due to Portal Cirhosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature William S. Womack M.D.
Address Bon Secours Hosp Date signed 10/5/48

G67450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 58 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ala. (b) County
(c) City or town Mobile (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 S. Conception St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WOODROW WILSON VAUGHAN

3 (b) If veteran, name war: WW 2

3 (c) Social Security Account No. 247-16-3630

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
m	w	s

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 10, 1913

8. AGE: Years	Months	Days	If less than one day
35	5	6	hr. min.

9. Birthplace Westville, Fla. (Town, county, and state)
10. Usual Occupation seaman
11. Industry or business seafarer

FATHER
12. Name Henry I Vaughan,
13. Birthplace Westville, Fla

MOTHER
14. Maiden Name Lillie Belle Pittman
15. Birthplace Baymonte, Fla

16 (a) Informant Records
(b) Address U. S. Marine Hospital

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10 10 48 (month) (day) (year)
(c) Cemetery or crematory DOTHAN
Location DOTHAN, ALABAMA.

18 (a) Funeral director JAMES F. DENNING INC.
(b) Address 715 LIGHT ST -30

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 7 - 1948

Washington Publishing Co., Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1948, at 3:15PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9, 1948 to Oct 6, 1948, and that I last saw him alive on Oct. 6, 1948.

Immediate cause of death	Duration
1-Malignant melanoma with widespread metastases	15 mo.
Due to	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy: not done	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson M. D.
Address Clinical Director Date signed 10-7-48

6674:51

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

6674:51
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 19 d.c.a.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 Frederick Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA A. REINACH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
White	Female	Widowed

6 (b) Name of husband or wife Sydney Reinach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1889

8. AGE: Years	Months	Days	If less than one day
59	6	19	hr. min

9. Birthplace (Town, county, and state)
10. Usual Occupation Restauranteur
11. Industry or business

FATHER
12. Name Louis Ruppersberger
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Zuang
15. Birthplace Baltimore, Maryland

16 (a) Informant Walter T. Voigt
(b) Address 1600 Frederick Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Frederick Road, Balto., Md.

18 (a) Funeral director Easton's Home
(b) Address 608 Fresh Air Ave. Catonsville
Thurlington for Williams, M.D.

19 (a) Date received OCT 1948 (Registrar)
(b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1948 at 6:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull
(b) Laceration of brain
Due to Intracranial hemorrhage
Fracture of neck
Other Conditions Fracture of ribs
Fracture of nose
(Include pregnancy within 3 months of death)

22. If an external cause was accident ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-5-48 at Approx. 6 p. M.
(b) Where did injury occur? 600 blk Frederick Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Ped. struck by auto.

23. Signature George C. Warren M.D.
Medical Examiner.
Date signed 10-6-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully checked.

74152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 66743?

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Valley & Eager St.
(c) Hospital or institution: Little Sisters of Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Little Sisters of Poor (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Krach

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife August

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1871

8. AGE: Years 77 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Norman F. Smith
(b) Address 2041 East 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) Funeral Director for Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 19 48, at 4:32 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 19 48, to Oct 6 19 48 and that I last saw h alive on Oct 6 19 48.

Immediate cause of death
Edema Lung — Duration 10 days
Due to Hypertensive Cardio — 3 yrs.
Due to Pulmonary Disease

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature [illegible]
Address 1631 E North Ave Date signed 10/7/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

667453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 667453 Registered No. 937

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1406 Filbert St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1406 Filbert St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William C. Pfarr

3 (b) If veteran, name war

3 (c) Social Security Account No. Lost

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Myrtle C Pfarr

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1900

8. AGE: Years 47 | Months 10 | Days 22 | If less than one day: hr. min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER 12. Name Christian Pfarr

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace "

16 (a) Informant Mrs. M. Pfarr

(b) Address 1406 Filbert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park,

Location Annapolis Md.

18 (a) Funeral director Chas. Hill

(b) Address 151 E. Fort Ave.

19 (a) OCT 8 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1948, at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Oct 1948.

and that I last saw him alive on Oct 4 1948.

Immediate cause of death Coronary occlusion

Due to Hypertension cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Philip W. Kuster MD

Address 312 Palafox Date signed 10/6/48

Kuster

67454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 67454

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital of Baltimore 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 3½ yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Brookfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. CALA BLUM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Albert H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1917

8. AGE: Years: 31 | Months | Days | If less than one day: hr. min.

9. Birthplace: Springfield Mass
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Israel Kuborutz
13. Birthplace: Russia

MOTHER
14. Maiden Name: Ida
15. Birthplace: Russia

16 (a) Informant: Albert H. Blum
(b) Address: 2502 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-48 (month) (day) (year)
(c) Cemetery or crematory: Kesser Israel
Location: Springfield, Mass

18 (a) Funeral director: Jacob Rewa Inc
(b) Address: 2160 Eutaw Place

19 (a) OCT 8 1948 (Date rec'd by registrar) (b) Huntington Millington Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948, at 12:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1948 to Oct. 8 1948 and that I last saw h&R alive on Oct 8 1948.

Immediate cause of death: Acute myelogenous leukemia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Aaron Sweed, M.D.
Address: Sinai Hospital Date signed 10/8/48

VS 150

67455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. 167455

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Fairview ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate BERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1880

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Latvia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Herman
13. Birthplace Latvia ?

MOTHER
14. Maiden Name Anda
15. Birthplace Latvia

16 (a) Informant Howard Berman
(b) Address 3510 Fairview ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-48 (month) (day) (year)

(c) Cemetery or crematory
Location Rodgers Friendship

18 (a) Funeral director Jack Lewis, Jr.
(b) Address 2620 Eutaw Place

19 (a) OCT 8 1948 (Date rec'd by registrar) (b) Huntington Pallbearers, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1948, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1948, to 10/7 1948, and that I last saw her alive on 10/7 1948.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Hypertensive Ht. Disease	
Left Ventricular failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maynard Oxenum, M.D. M. D.

Address Sinai Hosp. Baltimore Date signed 10/7/48

VS 150

X

067456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 067456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument Street
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Morley Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam Guercio (Saverio Rosario Guercio)

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-12-0157

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace (Town, county, and State)

10. Usual Occupation Shoemaker

11. Industry or business

FATHER 12. Name Pasquale Guercio

13. Birthplace Italy

MOTHER 14. Maiden Name Josephine Tepentino

15. Birthplace Italy

16 (a) Informant Steve Guercio

(b) Address 27 N. Morley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9-1948 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location 4300 Old Frederick Rd

18 (a) Funeral director Joseph Fanaco Inc.

(b) Address 2013 Greenmount Ave.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) Huntington for Millard M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 / 5 1948 at 11 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1948 to Oct 5 1948, and that I last saw h/m alive on Oct 5 1948.

Immediate cause of death	Duration
Acute Pulmonary Edema	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Being done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Sinai Hosp Date signed 10/6/48

VS 150

Natural Causes X

667457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

667457 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5906 Highgate Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5906 Highgate Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME IRVING BAER WEINBERG.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife DEANE Weinberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1899

8. AGE: Years	Months	Days	If less than one day
48	9	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Mfgr.
11. Industry or business

FATHER
12. Name Daniel Weinberg,
13. Birthplace Md.

MOTHER
14. Maiden Name Rena Baer,
15. Birthplace ?

16 (a) Informant Mrs. I. Weinberg
(b) Address 5906 Highgate Drive

17 (a) Cremation (b) Date thereof 10/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Harris Funeral Home
(b) Address 1812 Eutaw Place

19 (a) OCT 8 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1948 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1948 to Oct 7 1948.
and that I last saw him alive on Oct 7 1948.

Immediate cause of death Coronary Thrombosis — Duration 5 months

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

22 Signature Benj. D. Abelhouse M.D.
Address 100 W. Monument St. Date signed Oct 7, 1948

Benj. S. Abelhouse

VS 150

67458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 E

Registered No. 67458

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 414 E. Wolfe St.
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 E. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country B. W. I.

3 (a) FULL NAME Claude Adolphus Tulloch

3 (b) If veteran, name war None

3 (c) Social Security Account No. 220-05-4946

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Mary Tulloch

6 (c) If alive give age years

7. Birth date of deceased (mo., day, yr.) January 19, 1901

8. AGE: Years 47 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace St. Ann's Bay Jamaica (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Doris Stewart (Dept. Friend)
(b) Address 1641 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18. (a) Funeral director Robert L. Young
(b) Address 1216 W. Caroline St.

19 (a) OCT 8 - 1948 (Date rec'd by local registrar) (b) Huntington Williams Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1948, at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17 1948 to 10/7 1948 and that I last saw h[illegible] alive on 10/7 1948.

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to Myocarditis

Due to Lab-Hemolytic - Carbuncle Lymphoid 6/17/48

Other Conditions Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature Allen L. Lynch M. D.
Address 2220 N. Bond St. Date signed 10/7/48

VS 150

667459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

667459 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2613 Gilmore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Jarr

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. J. W. Jarr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28-1872

8. AGE: Years	Months	Days	If less than one day
75	10	9	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Louis Smith
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Norman Jarr
(b) Address 1425 N. Decker Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Co.
Location North Ave & Gay St

18 (a) Funeral director John A. Miller
(b) Address 2222 Jefferson St.

19 (a) OCT 8 1948 (Date rec'd by registrar) (b) Huntingtown Md. M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 19 48 at 9:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4 19 48, to 10/6 19 48, and that I last saw h alive on 10/5 19 48.

Immediate cause of death Coronary Thrombosis — Duration 1½ days

Due to intermediate

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address 3400 E. Fort Ave. Date signed 10/7/48

3400 E. Fort Ave.

667460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1242

667460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town Newark, (If outside city or town limits, write RURAL and give town)
(d) Street No. 283 Fairmount Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert DeMarco

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1917

8. AGE: Years 31 | Months 8 | Days 6 | If less than one day: hr. min.

9. Birthplace Newark, N. J. (Town, county, and state)

10. Usual Occupation Jockey

11. Industry or business

FATHER
12. Name Louis DeMarco
13 Birthplace Italy

MOTHER
14. Maiden Name Louise DiGianna
15. Birthplace Italy

16 (a) Informant Damiano Funeral Home
(b) Address Newark, N. J.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-8-48

(c) Cemetery or crematory Holy Sepulcher Cemetery
Location Newark, N. J.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

OCT 8 - 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1948, at 7:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy (Inspection or Inquiry), find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bronchopneumonia
Cardiac Failure
Fatty degeneration of liver

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place?
(d) Means of injury

23. Signature Emil H. Beyer M.D.
Medical Examiner
Date signed 10-7-48

VS 151

667461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667461

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 215 Longwood Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 79

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County 3

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 215 Longwood Road
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Virginia Stein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26/1865

8. AGE: Years 83 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Attilla Edward Stein M.D.
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Emerald Lawrence Stein
15. Birthplace Calvert Co.

16 (a) Informant William Henry Pilcher
(b) Address 215 Longwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-48 (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location North & Greenmount Aves. Balto.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams Md

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1948 at 5-05 P M

21. I certify that death occurred on the date above stated, that I attended deceased from January 1943 to Oct 6 1948, and that I last saw her alive on Oct 6 1948

Immediate cause of death
Left Hemiplegia — Duration 3 mos

Due to arteriosclerosis

Due to

Other Conditions Terminal Bronchopneumonia — 3 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Vernon H Norwood M. D.

Address 5101 Woodside Road Date signed 10-6-48

67462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667462

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stony Run Lane
(c) Hospital or institution: Hillcrest Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 Liberty Hts. Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No? If yes, name country

3 (a) FULL NAME Anna Louise Pracht

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13/ 1883

8. AGE: Years 65 | Months 1 | Days 28 | If less than one day: hr. 24 min

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Albert C. Pracht
13. Birthplace Maryland Balto.

MOTHER
14. Maiden Name Emma Baetjer
15. Birthplace Balto. Md.

16 (a) Informant Helen Pracht
(b) Address 204 Cedar Croft Rd.

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof Oct. 8/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn Md. Balto. city

18 (a) Funeral director John O Mitchell & Son
(b) Address 1900 Eutaw Pl.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) Huntington Phillips M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1948, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1941 to 10-6-1948, and that I last saw h alive on 10-5 1948.

Immediate cause of death: Pulmonary Cancer — Duration: 7 yrs.
Due to
Due to Myocardial failure — Duration: 2 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Francis T. Carne M.D.
Address 2834 Garrison Blvd. Date signed

VS 150

IMPORTANT. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G674663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G674663

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 N Luzerne Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) all of life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 N Luzerne Av (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Johanna Schoenhals

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry Schoenhals

6 (c) If alive, give residence

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1864

8. AGE: Years 84 | Months 7 | Days 2 | If less than one day: hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

MOTHER / FATHER

12. Name Mr William Tegeler

13. Birthplace Germany

MOTHER

14. Maiden Name Miss Elenora Schaffer

15. Birthplace Germany

16 (a) Informant Daughter

(b) Address 900 N Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9/48 (month) (day) (year)

(c) Cemetery or crematory Balto Cem

Location Balto

18 (a) Funeral director Wilhelm Funeral Home

(b) Address 2008 Orleans St

19 (a) OCT 8 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1948, at 8:25 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 16 1947, to Oct 6 1948, and that I last saw h[illegible] alive on Oct 6 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to Apoplexy	
Due to Hypertention	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur C Monninger M.D.

Address 900 E North Ave Date signed 10/7/48

VS 2

Med Ex's. Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 667464

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 S. Bouldin (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mrs. Anna Lizzie Critzman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife Wm. T. Critzman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 3, 1874

8. AGE: Years	Months	Days	If less than one day hr.	min.
74	7	4		

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Greenwald
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea Snyder
15. Birthplace Germany

16 (a) Informant Walter H. Critzman
b) Address 7009 Bartonia Ave

17 (a) Burial (Burial, cremation, or removal) b Date thereof Oct 11 (month) (day) (year)
(c) Cemetery or crematory St. Reformed Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Orleans St

19 (a) OCT 8 - 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1948, at 2:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from October 3, 1948 to October 7, 1948, and that I last saw her alive on October 7, 1948

Immediate cause of death	Duration
Coronary Occlusion	
Due to Hypertension C.V.D.	
Due to —	
Other Conditions Contusion Hip Right.	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10/3/48 at 1:30 AM
(c) Where did injury occur? Baltimore Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify) While at work?
(e) Means of injury Fell down stairs

23. Signature John T. Ennis
Address St. Joseph's

CERTIFICATION APPROVED BY D
Date signed 10/7/48

Earl Ross M.D.

VS 150

667465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667465

480

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2501 E. Chase Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 E. Chase Street (If rural give location)
(e) Citizen of foreign country? no Yes or No
If yes, name country

3 (a) FULL NAME MARY REBECCA SCHEPF

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or ~~wife~~ Howard Schepf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1896

8. AGE: Years	Months	Days	If less than one day
52	8	17	hr. min.

9. Birthplace Quantico, Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business National Can Company

FATHER
12. Name Boatwright
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mr. Howard Schepf - husband
(b) Address 2501 E. Chase Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)
(c) Cemetery or ~~Church~~ 1st United Evang. Luth.
Location

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) OCT 8 - 1948 (Date rec'd by Registrar) (b) Registrar Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6-1948, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21-1948 to 10-6-1948, and that I last saw h.. alive on 10-6-1948.

Immediate cause of death Carcinoma - Ca of ovary with metastases — Duration 1 year

Due to

Due to

Other Conditions Nephrostomy — 7 mos.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Benj. B. Moses M. D.
Address 448 N. Luzerne Ave Date signed 10-6-48

REPORT WRITTEN LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G87466

B-123450

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

9-27

Registered No. 687466

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 E. Jefferson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Schwarzkopf

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of [redacted] or wife Catherine Krieger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17- 1869

8. AGE: Years	Months	Days	If less than one day
79	3	18	hr. min.

9. Birthplace Md. Baltimore
(Town, county, and state)
10. Usual Occupation ? retired
11. Industry or business

FATHER
12. Name Henry Schwarzkopf
13. Birthplace ? Germany

MOTHER
14. Maiden Name Margaret
15. Birthplace ? Germany

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/9/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or [redacted] Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison St.

19 (a) OCT 8 - 1948 (b) Huntington Md.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948 at 10.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2- 1948, to 10-5- 1948, and that I last saw him alive on 10-5- 1948

Immediate cause of death: Cerebral Vascular Accident — Duration: 5 days

Due to Hypertensive Cardio Vascular Disease — Duration: ?

Due to — Duration: ?

Other Conditions arteriosclerosis gen. senes.
(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Krieger M.D.
Address Balto City Hosp Date signed 10-8-48

VS 150

Physician, Attention: Carefully read instructions. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 67407

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2707 White Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2707 White Avenue
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS ROOSEVELT BENDER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of ~~husband~~ or wife Margaret Kendrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1901

8. AGE: Years	Months	Days	If less than one day
47	7	20	hr. min.

9. Birthplace Port Deposit, Md.
(Town, county, and state)

10. Usual Occupation Landscaper

11. Industry or business

MOTHER / FATHER

12. Name Alfred Bender

13. Birthplace Philadelphia, Pa.

14. Maiden Name Mary Jane Long

15. Birthplace Philadelphia, Pa.

16 (a) Informant Mrs. Margaret Kendrick Bender

(b) Address 2707 White Avenue

17 (a) Burial (b) Date thereof 10/9/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or ~~crematory~~ Moreland Mem. Park
Location 5806 Harford Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.

(b) Address 2601-3-5 E. Madison Street

19 (a) OCT 8 - 1948 (b) Curtis Bay Williamsport, Md.
(Date rec'd by Local Registrar)

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1948 at 10 ~~P~~ A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1948 to Oct 6 1948.
and that I last saw h~~im~~ alive on Oct. 6 1948.

Immediate cause of death Coronary occlusion — Duration

Due to Coronary Sclerosis

Due to Hypertension

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Walter A Anderson M.D.

Address 3001 Shannon Drive Date signed 10/7/48

67468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 67468 Registered No. 1248

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2714 Berwick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2714 Berwick Ave (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME John J. Miceli

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Augusta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 19-1877

8. AGE: Years	Months	Days	If less than one day
71	6	18	hr. min.

9. Birthplace Italy (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph Miceli
13. Birthplace Italy

MOTHER
14. Maiden Name ✓
15. Birthplace Italy

16 (a) Informant Mrs. John Dockman
(b) Address 2714 Berwick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn N. Y. Luck

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) Huntington Station, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1948, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1948, to Oct 1948, and that I last saw h[illegible] alive on Oct 7 1948.

Immediate cause of death Cardiac decompensation — Duration

Due to Old Myocardial Infarction

Due to Coronary Thrombosis 1946

Other Conditions Cirrhosis of liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Thomas J. Brennan M. D.
Address 5217 Harford Rd Date signed 10-8-48

VS 150

95c

G67469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G67469 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4406 Rokeby Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Yrs. Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4406 Rokeby Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Caroline Lippert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Widow

6 (b) Name of husband or wife Late Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1875

8. AGE: Years	Months	Days	If less than one day
73	3	22	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Wm. Hoffman
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Gettier
15. Birthplace Md.

16 (a) Informant Ruth Hardt
(b) Address 4406 Rokeby Rd.

17. Burial (b) Date thereof Oct. 11 | 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry R. Weitzel
(Address) 401 Edmondson Ave.

19 (a) Oct 8 - 1948 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948, at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1948 to Oct 8 1948, and that I last saw her alive on Oct 7 1948.

Immediate cause of death	Duration
Carcinoma of Esophagus	?
Due to	
Due to	
Other Conditions Left Hemiplegia	3 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl Cass, M.D.
Address 4001 Wilkens Ave. Date signed 10-8-48

VS 180

67470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(21)

✓ 67470 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 W. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 W. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Cuff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Widow

6 (b) Name of husband or wife Homer Cuff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1882

8. AGE: Years 66 | Months 8 | Days 2 | If less than one day hr. min.

9. Birthplace Charles Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Elijah Holt
13. Birthplace Charles Co. Md.

MOTHER 14. Maiden Name Mary Thomas
15. Birthplace Charles Co. Md.

16 (a) Informant Marie Cooper
(b) Address 2520 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St Huntington Williams Md

19 (a) OCT 8 - 1948 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1948, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1947 to Oct 6 1948.
and that I last saw h alive on Oct 6 1948.

Immediate cause of death Cardiac Arrest — Duration Minutes

Due to Cerebral Thrombosis

Due to Renal Pelvis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify) (State)
Means of injury

23. Signature Helen F. Cooper
Address 2015 Edmondson Date signed 10/10/48

VS 150

G67471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 ✓

G67471
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1438 Carroll St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1438 Carroll St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Woolford.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 23, 1896.

8. AGE: Years	Months	Days	If less than one day
52	8	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Nathan Woolford.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Sallie Woods.
15 Birthplace Baltimore Md.

16 (a) Informant Mrs. Sadie Bryan.
(b) Address 1439 Ward St.

17 (a) Is Burial (b) Date thereof October 9, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie L. Williams
(b) Address 32½ N. Schroeder St

19 (a) OCT 8 - 1948 (b) Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1948, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1947 to Oct 6 1948, and that I last saw h[illegible] alive on Oct 6 1948.

Immediate cause of death	Duration
Cerebral Thrombosis left	3 days
Due to Chronic Myocarditis & myocardial Degeneration	2 years
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich, Jr. M. D.
Address 122 N. Ward Blvd Date signed 10-7-48

VS 150

G67472 Bl 6

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67472 ✓ Registered No. 121a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2037 Harford Road (If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country

3 (a) FULL NAME William McKeldin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-1-83

8. AGE: Years	Months	Days	If less than one day
65	4	6	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER 12. Name William McKeldin
13. Birthplace ?

MOTHER 14. Maiden Name Mary Scott
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48
(c) Cemetery or crematory Mt. Olivet Cem.
Location Frederick Rd.

18 (a) Funeral director Thos. H. Valentine
(b) Address 2326 Aiken St.

19 OCT 8 - 1948 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7 1948, at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1948 to 10-7 1948.
and that I last saw h alive on 10-7 1948.

Immediate cause of death	Duration
Uremia	
Due to Arteriosclerotic cardio-renal disease	
Due to Generalized arteriosclerosis	
Other Conditions Emphysema-senile	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: ASCVD E emphysema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [illegible]
Address The Johns Hopkins Hosp Date signed 10/7/48 M. D.

674473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(31)

Registered No. 674473

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1412 Tracton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Tracton St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Marie West Hall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife John Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 17, 1904

8. AGE: Years 43 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Mack West
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mildred Young
(b) Address 1412 Tracton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Presstman St

19 OCT 8 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1948, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1948 to Oct 6 1948 and that I last saw her alive on Oct 4 1948.

Immediate cause of death Cardio Vascular Disease — Duration 2 yr.

Due to Lymph angioma of both legs — 2 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E William Frey M.D.
Address 1928 Penna Ave Date signed 10/8/48

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

To be Approved by Chief Medical Examiner

Medical Examiner's Case 67474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67474

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2626 Yorkway
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

CERTIFICATION APPROVED BY

3 (a) FULL NAME FRANK W SRAVER

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife ETHEL T TURNER
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr SEPT. 29, 1891

8. AGE: Years 57 | Months 0 | Days 16 | If less than one day hr min.

9. Birthplace BALTO., MD. (Town, county, and state)

10. Usual Occupation R. R. CONDUCTOR RET.

11. Industry or business B & O. RAILROAD

FATHER
12. Name WM. SRAVER
13. Birthplace

MOTHER
14. Maiden Name KATHERINE
15. Birthplace

16 (a) Informant MRS. RUSSEL LANDON
(b) Address 2626 YORKWAY

17 (a) BURIED (Burial, cremation, or removal) (b) Date thereof OCT. 9 1948 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEM.
Location 7225 EASTERN AVE.

18 (a) Funeral director Roland L Trader
(b) Address 212 DUNDALK AVE

19 (a) OCT 8 1948 (Date received by Registrar) (b) Huntington Nelson Registrar

MEDICAL CERTIFICATION M. D.
CHIEF OR ASST. MEDICAL EXAMINER

20. DATE OF DEATH 10-6 1948, at 2:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9-28 1948, to 10-6 1948, and that I last saw him alive on 10-6 1948.

Immediate cause of death Acute Pulmonary Edema & Pulmonary Emphysema — Duration 3 days

Due to Hypertensive Arteriosclerotic Cardiovascular Disease — Duration 10 years

Due to — Duration

Other Conditions Attempted Suicide June 2 Manic Depressive State — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Pulmonary Edema & Emphysema

of autopsy: Hypertension A530.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

CERTIFICATION APPROVED BY
M. D.
CHIEF OR ASST. MEDICAL EXAMINER

CERTIFICATION BY Edward A. Newell M. D.
Address 213 Light St. Date signed 10-6-48

VS 150

CHIEF OR ASST. MEDICAL EXAMINER

HLH Prem

GRANICKI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667475

667475 BC-48-21730 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 14 S. Ann St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bruno Boy Granicki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Theodore Granicki

13. Birthplace Balto md

MOTHER 14. Maiden Name Wanda Borys

15. Birthplace Balto Md

16 (a) Informant Theodore Granicki

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8 48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem Location German Hill road

18 (a) Funeral director Maria E. Fratkowski

(b) Address 1000 N. Kenwood Ave

19 (a) OCT 8 - 1948 (Date filed by registrar) (b) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1948. at 7.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1948. to 10-7 1948. and that I last saw him alive on October 7 1948.

Immediate cause of death: Pneumonitis * Atelectasis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature Upami Upmes

Address JHH Date signed 10/8/48

VS 150

G67476

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92

G67476
Registered No.

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave.
(c) Hospital or institution: Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN W. BOWEN, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Annie D. Bowen nee Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1860

8. AGE: Years	Months	Days	If less than one day
88	7	23	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Special Agent
11. Industry or business Timbrooks & Zimmerson

FATHER
12. Name George W. Bowen
13. Birthplace Md.

MOTHER
14. Maiden Name Malinda A. Nash
15. Birthplace Maryland

16 (a) Informant Mr. John W. Bowen, Jr., son
(b) Address 2420 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem. Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 1948 to 10/6 1948 and that I last saw h[illegible] alive on 10-6 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 hrs
Arterio Sclerosis	
Due to arterio sclerosis	4 yrs
Due to	
Other Conditions Prostatitis - Operation (Include pregnancy within 3 months of death)	
Date of operation Oct 8, 1948	
Major findings of operation: Prostatic Hypertrophy	
of autopsy: Blood	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury (Specify fully and exactly)

23. Signature [signature] M. D.
Address 2040 N. Charles Date signed 10/8/48

VS 150

67477

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

Registered No. 67477

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 335 E. 27th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 335 E. 27th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT B. COLBERT, Sr.

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Harriett A. Colbert
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 7, 1890
8. AGE: Years 58 | Months 0 | Days 9 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Supt.
11. Industry or business J. F. . Dorman Co.

FATHER
12. Name Robert B. Colbert
13 Birthplace Maryland

MOTHER
14. Maiden Name Kate Callahan
15 Birthplace Maryland

16 (a) Informant Mrs. Harriett A. Colbert, Sr.
(b) Address 335 E. 27th St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) OCT 8 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1948, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 8, 1947 to Oct. 6, 1948 and that I last saw h~~im~~ alive on Oct. 6, 1948

Immediate cause of death: Myocardial Failure — Duration: Immediate
Due to Chronic Hypertension — Duration: 2 years.
Due to
Other Conditions Arteriosclerosis. — Duration: 2 years.
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: none.
of autopsy: none.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence None at M
(c) Where did injury occur? None. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None. (Specify) While at work?
(e) Means of injury None.

23. Signature Frank H. Ogden, M. D.
Address 2701 N. Calvert St. Date signed Oct. 7, 48.

VS 150

102

67478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. 67478

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2730 The Alameda
(c) Hospital or institution:

919

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2730 The Alameda
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BEVERLY R. REID

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Spanish	no	male	white	widowed

6 (b) Name of husband or wife Grace L. Reid
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1878

8. AGE: Years	Months	Days	If less than one day
70	2	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Robert M. Reid
13. Birthplace Scotland

MOTHER 14. Maiden Name Henrietta Burrough
15 Birthplace Virginia

16 (a) Informant Miss Marion Reid
(b) Address 2730 The Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) Huntington Pittenger M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1948, at noon M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to Oct 7 1948.
and that I last saw h alive on Oct 6 1948

Immediate cause of death 1 Chronic Endocarditis — Duration 2 ?
Due to Failing Compensation 1 mo
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. P. Pittenger M.D.
Address 9356 Maryland Ave Date signed Oct 8 48

VS 150

Hal-7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 B

Registered No. 667479

667479

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1136 Metzger Way (If rural give location)
(e) Citizen of foreign country? Yes or No? If yes, name country

3 (a) FULL NAME David Shook

3 (b) If veteran, name war

3 (c) Social Security Account No. 234-10-4948

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Marjorie Shook
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr) 3-19-16

8. AGE: Years	Months	Days	If less than one day
32	6	18	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business

FATHER
12. Name William Shook
13. Birthplace W. Va.

MOTHER
14. Maiden Name Josephine Cockran
15. Birthplace W. Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/8/48 (month) (day) (year)
(c) Cemetery or crematory Shinnston Masonic Cem.
Location Shinnston, W. Va.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Baltimore, Md. Plummer, W. Va.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1948, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1948 to 10-7 1948, and that I last saw him alive on 10-7 1948.

Immediate cause of death: Brain Tumor

Duration:

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct 7, 48

Major findings of operation: Brain tumor rt temporal lobe

of autopsy: Brain Tumor Temporal lobe

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature George E. Culbreth M. D.
Address Johns Hopkins Hospital Date signed Oct 8 1948

VS 159

667480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 667480

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5204 Tilbury Way

(c) Hospital or institution: at Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) ~~County~~ City of Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5204 Tilbury Way (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME MARGARET PAINTER SHRYOCK

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.: Married

6 (b) Name of husband or wife: Henry S. Shryock

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Dec-7-1885

8. AGE: Years 62 | Months 10 | Days 0 | If less than one day: ..... hr. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: None

11. Industry or business: None

FATHER

12. Name: Harold C. Painter

13. Birthplace: Owings Mills, Maryland

MOTHER

14. Maiden Name: Carrie Toole Hill

15. Birthplace: Louisburg, N. C.

16 (a) Informant: Mr. Henry S. Shryock, Jr. (son)

(b) Address: 3420 Fairhill Dr, Wash, D. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-9-48 (month) (day) (year)

(c) Cemetery or crematory St. Thomas Garrison Forest

Location Owings Mills, Maryland

18 (a) Funeral director: Stewart & Mowen Company

(b) Address: 108 W. North Avenue, City #1.

19 (a) OCT 8 - 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1948, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1948 to Oct 7 1948.

and that I last saw her alive on Oct 6 1948.

Immediate cause of death: Uremia — Duration: 3 days

Due to: Vesical carcinoma & metastases — 6 mo.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Stephen J Van Lill

Address 2743 St Paul St Date signed 10-8-48

M. D.

VS 150

Medical Examiner's Case

G67481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G67481

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 N. Broadway
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 W. Patterson Pk. Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Claire M. Ford

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: John T. Ford

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) April 28, 1888

8. AGE: Years 60 | Months 5 | Days 12 | If less than one day — hr. — min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name James O. Oneil
13. Birthplace Maryland

MOTHER
14. Maiden Name Eleanor Ruth
15. Birthplace Maryland

16 (a) Informant MRS Claire M. Ford.
(b) Address 1419 Pattersson Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3060 E. Balt. St.

OCT 8 - 1948 (Date rec'd by registrar)

Huntington Maryland (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~April 29~~ Oct. 6 1948, at 7:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1948 to Oct 6 1948. and that I last saw her alive on Oct 6 1948.

	Duration
Immediate cause of death Infarction of Myocardium due to arterio-sclerotic coronary Thrombosis	9/29/48
Due to	
Due to Arteriosclerotic Heart Disease	10 years
Other Conditions Hypertensive Cardiovascular Disease 10 yrs. Fracture Left radius. 9/18/48	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: CERTIFICATION APPROVED BY PHYSICIAN

of autopsy: — M. D.

CHIEF OF BOST. MEDICAL EXAMINER.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Sept. 19, 1948 at — M
(c) Where did injury occur? 1419 N. Patterson Pk. Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Tripped over linoleum and fell to floor.

23. Signature L. M. Howard, M.D.
Address Church Home Hospital
Date signed 10/6/48

CERTIFICATION APPROVED BY M. D.

M. E.

VS 150

667482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667482

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Galveston (If outside city or town limits, write RURAL and give town)
(d) Street No. Apt 107-A, Island City Homes (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WALTERS, HERBERT RODNEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife [redacted]

6 (c) If alive, give age [redacted] years

7. Birth date of deceased (mo., day, yr.) July [redacted], 1926

8. AGE: Years	Months	Days	If less than one day
22	2	26	..... hr. ..... min.

9. Birthplace Texas (Town, county, and state)
10. Usual Occupation seaman
11. Industry or business seafarer

FATHER
12. Name Rudolph Walters
13. Birthplace Texas

MOTHER
14. Maiden Name Clara Brundrett
15. Birthplace Texas

16 (a) Informant Records
(b) Address U. S. Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct-8-48 (month) (day) (year)
(c) Cemetery or crematory Galveston
Location Texas

18 (a) Funeral director Ralph B Wolverton Inc
(b) Address 423 E - 25th St.

19 (a) OCT 8 - [redacted] (Date rec'd by registrar) (b) Huntington Williamson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1948, at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16, 1948 to Oct. 7, 1948, and that I last saw him alive on Oct. 7, 1948

Immediate cause of death	Duration
Acute Myeloid Leukemia	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. B. Monroe M. D.
Address USMH, Balto Date signed 10-7-48

V S 150

BC-48-2160 2

667483

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667483 Registered No. 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Ms
(c) Hospital or institution: Rutland Ave Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 Abbott Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Joseph (Bobby Boy) Brown Jr

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5 1948

8. AGE: Years	Months	Days	If less than one day
		4 3	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

MOTHER / FATHER
12. Name Walter J. Brown
13. Birthplace Baltimore Md
14. Maiden Name Angeline Guglielmo
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Walter J. Brown
(b) Address 824 Abbott Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)
(c) Cemetery or crematory Sa cred Heart Cemetery
Location Gunpowder Hoffman Road Rte 40

18 (a) Funeral director Edward W. Carlin
(b) Address 924 E. Eager St.

19 OCT 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948, at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1948 to Oct 8 1948, and that I last saw him alive on Oct 7 1948.

Immediate cause of death respiratory failure

Due to anoxia

Due to Congenital heart disease, eg. atresia of pulmonary ring

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Josephs M. D.
Address Sinai Hosp Date signed 10-8-48

G67484

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G67484

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Rosewood Training School
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 mos 12
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Baltimore
(c) City or town: Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Reginald Pyles

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	Married

6 (b) Name of husband or wife: Wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct 5 1887

8. AGE: Years	Months	Days	If less than one day
60	11	22	hr. min.

9. Birthplace: Md (Town, county, and state)
10. Usual Occupation: Attendant
11. Industry or business: (Rosewood Training Sch)

FATHER
12. Name: Wallace Pyles
13. Birthplace: Maryland

MOTHER
14. Maiden Name: [redacted] Price
15. Birthplace: Maryland

16 (a) Informant: Wilhemina Pyles (Wife)
(b) Address: 1711 N Wood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)
(c) Cemetery, or crematory: Maryland Park
Location: Northville Md

18 (a) Funeral director: Wm Cook Inc
(b) Address: 617 E Lexington St

19 (a) OCT 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-7 1948, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948 to Oct 7 1948, and that I last saw h[illegible] alive on Oct 7 1948.

Immediate cause of death	Duration
Cardio-respiratory collapse	
Due to Cerebral Embolism	
Due to	
Other Conditions Fract-radius right [illegible] Fract-supracondyles humerus right	2½ mos.

(Include pregnancy within 3 months of death)

Date of operation: 10
Major findings of operation:
of autopsy:

CERTIFICATION APPROVED BY
Thos E. Morrill M.D.
CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence: 9-26-48 at about noon M
(c) Where did injury occur? (Rosewood) Owens Mills (City or town) Baltimore (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Rosewood Boys Home (Specify home, farm, etc.) While at work? Yes
(e) Means of injury: Accidentally knocked to floor

23. Signature: J. Swan M.D.
Address: Owings Mills Date signed: 10-7-48

J. Swann

667485

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

667485 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 Cliftview Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 Cliftview Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Loretta E. Magness

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1910

8. AGE: Years	Months	Days	If less than one day
38	8	9	10 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William W. Magness
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Maud Blum
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. E. Magness
(b) Address 1506 Cliftview Aveme

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 OCT 9 - 1948 (Date rec'd by Registrar) (b) Huntington Pollimore, Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1948 at 1:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1946 to Oct 7 1948.
and that I last saw her alive on Oct 6 1948

Immediate cause of death: Carcinoma of breast — Duration: 2 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Joseph Pokorny Jr M.D.
Address 2200 E Madison St Date signed 10/8/48

667486

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

832

667486

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Green

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 3203 Bayonne Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME AULT ELMER F

3 (b) If veteran, name war NO

3 (c) Social Security Account No. 212-09-1989

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife H. Edith Ault

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) JAN. 29 - 1897

8. AGE: Years	Months	Days	If less than one day
51	8	9	10 hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation salesman

11. Industry or business C.D. KENNY CO.

FATHER — 12. Name Elmore Ault

FATHER — 13. Birthplace Md.

MOTHER — 14. Maiden Name Fredricka Hacker (HECKER)

MOTHER — 15. Birthplace Md.

16 (a) Informant H Edith Ault

(b) Address 3203 Bayonne Av.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-11-48 (month) (day) (year)

(c) Cemetery or crematory OAKLAWN

Location BALTIMORE

18 (a) Funeral director JOHN T. STRINGBURY

(b) Address 2700 EDMONDSON AVE.

19 (a) OCT 9 - 1948 (Date rec'd by registrar) Catherine Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8/48 19 , at 9 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8 19 48 to 9/8 19 48, and that I last saw h[illegible] alive on 9/8/48 19

Immediate cause of death

Cardio-respiratory failure

Due to Sub-Arachnoid hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jos Shear M.D.

Address [illegible] Date signed 9/8/48

VS 150

G67487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 929

Registered No. G67487

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1419 S. Charles St.

(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) almost 60 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1419 S. Charles St. (If rural give location)

(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME Magdalene (Lena) White

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Colan White

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 15, 1870

8. AGE: Years 78 | Months 4 | Days 21 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business —

FATHER: 12. Name Adolph Obeim

13. Birthplace Germany

MOTHER: 14. Maiden Name Marie Eva Langhauer

15. Birthplace Germany

16 (a) Informant Mrs. Catherine Plea (niece)

(b) Address 1419 S. Charles St., Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9, 1948 (month) (day) (year)

(c) Cemetery or crematory Western Cem.

Location Balto. Md.

18 (a) Funeral director A. Howard Evans

(b) Address 1600 S. Charles St Balto 30 Md.

1948 OCT 9 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Wed., Oct. 6, 1948 at 2:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1948 to 10/6 1948 and that I last saw h[illegible] alive on 10/6 1948.

Immediate cause of death Acute cardiac failure, associated with arteriosclerotic heart disease — Duration 3 days

Due to —

Due to —

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)

(e) Means of injury —

23. Signature Harry Weiss

Address 126 Hanover St. Date signed 10/5/48

VS 150

667488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. 667488

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2712 Allendale Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2712 Allendale Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THELMA R. KING

3 (b) If veteran, name war: no

3 (c) Social Security Account No.:

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Robert W. King

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 12, 1900

8. AGE: Years: 47 Months: 11 Days: 26 If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: U. S. F. & G. Co.

FATHER 12. Name: Charles E. Roberts

13. Birthplace: Dorchester Co., Md.

MOTHER 14. Maiden Name: Mary E. Insley

15. Birthplace: Dorchester Co., Md.

16 (a) Informant: Mrs. Alva Ryall

(b) Address: 2712 Allendale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/48 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) OCT 9 - 1948 (Date rec'd by Registrar) (b) Filed Oct. 11, 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 6, 1948 at 7:15 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 18 1946 to Oct 6 1948 and that I last saw h[illegible] alive on Oct 6 1948.

Immediate cause of death: a. Pneumatic Heart b. Cardiac Hypertrophy

Duration: 6 years

Due to: Aortic Insufficiency with incompetency

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature [illegible] Address 2911 Barnard Rd. Date signed 10-8-48

VS 150

667489 J - 116473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12R

667489 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 3
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 Ettings St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer Hunt

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-6501

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1891

8. AGE: Years	Months	Days	If less than one day
57	6	1029	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER	12. Name	Henry Hunt
	13. Birthplace	Md.
MOTHER	14. Maiden Name	Emma Matthews
	15. Birthplace	Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Jno. George A. Hallenan
(b) Address 1631 Orchid St. Baltimore, Md.

19 OCT 9 1948 Timothy Williams, M.D. (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1948, at 8 PM M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 9 1948 to Oct. 6 1948, and that I last saw h im alive on Oct. 6, 1948

Immediate cause of death: Pulmonary tuberculosis — Duration: 7 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Gayle Burton
Address Baltimore City Hospitals Date signed 10/7/48

67490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

829

Registered No. 67490

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2304 Division Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2304 Division Street (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME PATSY MOYLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Aug. 4, 1882

8. AGE: Years 66 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Smithfield, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Elijah Spradley

13. Birthplace Virginia

MOTHER 14. Maiden Name Jane Diggs

15. Birthplace Virginia

16 (a) Informant Jannie Carter

(b) Address 2304 Division Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9, 1948 (month) (day) (year)

(c) Cemetery or crematory Family lot

Location Smithfield, Va.

18 (a) Funeral director Mrs? George H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) OCT 9 1948 (Date rec'd by Registrar) Huntington Williams Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1948 at 1:50 P M

21. I certify that death occurred on the date above stated that I attended deceased from Sept 29 1948 to Oct 7 1948.

and that I last saw h alive on Oct 7 1948

Immediate cause of death Cerebral hemorrhage — Duration Eight days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R Garland Schmidt

Address 1534 Druid Hill Ave Date signed Oct. 8, 1948

VS 150

67491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67491

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Baltimore,
(c) City or town (If outside city or town limits, write RURAL and town)
(d) Street No. 610 Washburn Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME RAYMOND A. PORTER

3 (b) If veteran, name war: One

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary A. Porter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19-1894

8. AGE: Years 53 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Cumberland, Md. (Town, county, and state)

10. Usual Occupation Ammunition

11. Industry or business Inspector U.S.A.

FATHER
12. Name Unknown
13. Birthplace Pa.

MOTHER
14. Maiden Name Unknown
15. Birthplace Pa.

16 (a) Informant Mrs. Mary A. Porter
(b) Address 5407 E. Drive Baltimore 7

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12, 1948 (month)
(c) Cemetery or crematory National
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 OCT 9 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1948 at 1 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull & intra cranial hemorrhage

Due to

Other Conditions (Include pregnancy within three months of death)

22. If an external cause was indicated X or suspected ☐ cause of death, fill in the following:
(a) Date of injury 10-8-48 at 11:15 P.M.
(b) Where did injury occur? Patapsco Ave. & 6th St. Brooklyn
(c) Did injury occur at home, on farm, industrial place, in public place? public Was it accidental? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Emil K. Rogge M.D.
Medical Examiner
Date signed 10-9-48

667492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1112

Registered No. 667492

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 N Paca St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County
(c) City or town Elkhurst (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 10 41st Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Albert Brovst

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/25/25

8. AGE: Years 22 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace New York City N. Y. (Town, county, and state)

10. Usual Occupation Seminarian

11. Industry or business St. Mary's Seminary

FATHER
12. Name Rudolph Provst
13. Birthplace Germany

MOTHER
14. Maiden Name Antonia Myer
15. Birthplace Germany

16 (a) Informant Gerard Neufeld
(b) Address 805 Broadway, Elmhurst N. Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory St. John's Cemetery
Location Middle Village, L. I. N. Y. C.

18 (a) Funeral director H. H. Ulmears and Son
(b) Address 805 N Calvert St

19 (a) (Date received by registrar) OCT 9 1948 (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1948, at 5 45 P M

21. I certify that I took charge of the remains described above, held an Inq & Insp thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Find death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Stefinak M.D.
Medical Examiner.
Date signed Oct 8, 1948

667493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1862

Registered No. 667493

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 4004 Pinewood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARDO ALIAMO

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-2272

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Sara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1892

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56	9	1		

9. Birthplace Sicily, Italy (Town, county, and state)
10. Usual Occupation Timber Man
11. Industry or business Pipe Laying

FATHER
12. Name Phillip Alaimo
13. Birthplace Italy

MOTHER
14. Maiden Name Anna ?
15. Birthplace Italy

16 (a) Informant: Phillip Aliamo
(b) Address 4004 Pinewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road & Moravia Avenue

18 (a) Funeral director Frank Della Noce
(b) Address 322 S. High Street

OCT 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1948 at 4:38 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-7-48 at 3:50 P. M.
(b) Where did injury occur? Northern Parkway and Chinquapin Driveway
(c) Did injury occur at home, on farm, in factory, or public place? Industrial While at work? Yes
(d) Means of injury Cave-in (Laying drain pipe in trench)

23. Signature Earl E. Krug M.D.
Medical Examiner
Date signed 10-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. 52-6[illegible]

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1341-Gilmore St., 15

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1341-Gilmore St. (If rural give location)

(e) Citizen of foreign country? O (Yes or No)

If yes, name country

3 (a) **FULL NAME** Walter Bulls.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-6045

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5-1948 M

4. Sex M. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-10-1900

8. AGE: Years 48 | Months - | Days 25 | If less than one day hr min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Bulls

13. Birthplace S. C.

MOTHER 14. Maiden Name Gaston

15. Birthplace S. C.

16 (a) Informant Mary Bulls

(b) Address 1340-Gilmore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary.

Location Catonsville

18 (a) Funeral director A. Holland

(b) Address 916 Lemmon Street

19 OCT 9-1948 (Date rec'd by Registrar) (b) Huntington Williams

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1-1948 to 10-5-1948 and that I last saw him alive on 10-4-1948

Immediate cause of death (a) Cardiac (Coronary) Occlusion

Due to myocarditis

Due to Nephritis

Due to Gastritis

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration: Few Months

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)

(e) Means of injury —

23. Signature W. R. Boyken

Address 1133 Monroe Date signed 10/7/48

VS 190

G67495

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 44 [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1y 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Pittman Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Melvin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: female | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-9-09

8. AGE: Years 39 | Months 8 | Days 29 | If less than one day: hr. min.

9. Birthplace No. Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Solomon Williams
13. Birthplace No. Carolina

MOTHER
14. Maiden Name Martha ?
15 Birthplace No.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 10-9-48 (month) (day) (year)
(c) Cemetery or crematory Location Warsaw N. C.

18 (a) Funeral director A. Tolbert
(b) Address 918 Druid Hill Ave.

19 OCT 9 (Date rec'd by registrar) Baltimore, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1948, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1948, to 10/7 1948, and that I last saw h[illegible] alive on 10/7 1948.

Immediate cause of death
subarachnoid hemorrhage
presumably
Due to Ruptured aneurysm of circle of Willis
Due to
Other Conditions Essential hypertension, history
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: none performed

Division

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(e) Means of injury

23. Signature John Collins Harvey M.D.
Address Johns Hopkins Hospital Date signed 10-8-48

667496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

667496 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1626 Ashland ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1626 Ashland ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ophelia Bantop

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5-1897

8. AGE: Years	Months	Days	If less than one day
50	10	2	hr. min.

9. Birthplace King & Queen Co. Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER

12. Name James Pollard

13. Birthplace King & Queen Co. Va

MOTHER

14. Maiden Name Emma Baytop

15. Birthplace King & Queen Co. Va

16 (a) Informant James C. Pollard

(b) Address 1804 N. Bouvier St. Phila Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11-48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn Va.

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Bantly ave Huntington Wabash Mass

19 (a) OCT 9 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION OCT 7-48

20. DATE OF DEATH Oct. 7th 1948, at 2 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Septem 1948 to Oct 7 1948 and that I last saw h alive on Oct 2 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage.	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Truehart

Address 1623 E. N. Ave Date signed 10/8/48 M/D/Y

VS 150

667497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667497

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3329 Avondale Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3329 Avondale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MILTON E. LIST

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widower
6 (b) Name of husband or wife: Ida List
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr): Sept. 11, 1879
8. AGE: Years: 69 Months: 0 Days: 27 If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Laborer
11. Industry or business: Baltimore Transit Co.

FATHER
12. Name: George List
13. Birthplace: At Sea

MOTHER
14. Maiden Name: Johanna Bailey
15. Birthplace: Pa.

16 (a) Informant: Mr. John F. List, brother
(b) Address: 3329 Avondale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory: Western Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 9 - 1948 (Date received by registrar) Washington Wilmington, N.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8, 1948, at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1948, to Oct 7 1948, and that I last saw h(er) alive on Oct 7 1948.

Immediate cause of death	Duration
Cardio Vascular Disease	2 mos
Due to Arteriosclerosis	2 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest Green M. D.
Address 101 Professional Bldg Date signed Oct 8, 1948

VS 150

BC-548-2178 ✓

667498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. 667498

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 Fait Ave # 26 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy GIBSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 Oct 48

8. AGE: Years	Months	Days	If less than one day
0	0	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER
12. Name Russel Edward GIBSON
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dorothy Rita LASER
15. Birthplace Baltimore

16 (a) Informant Father
(b) Address (above)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 9 48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk ave -

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 410 [illegible] Baltimore, Md.

19 (a) [illegible] (b) [illegible] Registrar
(Entered by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Oct 1948 at 606 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7 Oct 1948 to 9 Oct 1948. and that I last saw h[illegible] alive on 9 Oct 1948

Immediate cause of death: Atelectasis, Congenital — Duration 2d.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Atelectasis Congenital

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert K. Schoenheider M. D.
Address Maryland Gen. Hosp. Date signed 9 Oct 48

X

667493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667493

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2732 N. Paul St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2732 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella M. Madden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/23/73

8. AGE: Years 74 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas F. Madden
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna Cahill
15. Birthplace Ireland

16 (a) Informant Julia C. Madden
(b) Address 2732 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meyers and Son
(b) Address 80 W. Lafayette St. Baltimore, Md.

19 (a) 10 [illegible] 48 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Oct. 1948, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Vascular Accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury, at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D. Medical Examiner.
Date signed 8 Oct. 1948

VS 151

67500

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. (illegible)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 125 S. East Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 S. East Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John L. Norton

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife: Sarah F. Norton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 25, 1861

8. AGE: Years	Months	Days	If less than one day
86	10	15	hr. min.

9. Birthplace: Middleseat, Va. (Town, county, and state)
10. Usual Occupation: Engineer
11. Industry or business

FATHER
12. Name: Ben Norton
13. Birthplace: Va

MOTHER
14. Maiden Name: Elizabeth Clark
15. Birthplace: Louisana

16 (a) Informant: Mrs. Sarah F. Norton
(b) Address: 125 S. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: 3800 Frederick Ave
18 (a) Funeral director: Howard J. Biggs
(b) Address: 6007 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 10 1948

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/9 1948 at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8 1948 to 10/9 1949, and that I last saw h[im] alive on 10/8 1948.

Immediate cause of death: Cerebro vascular accident — Duration: 4 hrs

Due to: Generalized arteriosclerosis Hypertension — yrs

Due to: — yrs

Other Conditions: none

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: none

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: no
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Maurice Feldman Jr M.D.
Address: 817 St Paul St Date signed 10/9/48

667501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 667501

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2317 Whittier Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 Whittier Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH GOLDFUSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1874

8. AGE: Years 74 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business: Roofing Business

FATHER
12. Name: Laib Mayer Goldfuss
13. Birthplace: Russia

MOTHER
14. Maiden Name: Unkown
15. Birthplace: Russia

16 (a) Informant: Leah Goldfuss
(b) Address: 2317 Whittier Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 1 (month) (day) (year)
(c) Cemetery or crematory: Sharrei Tfiloh Cem
Location: Windsor Hill Road

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) OCT 10 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1948 at 2 A. M

21. I certify that death occurred on the date above stated that I attended deceased from Oct 1 1948 to Oct 10 1948, and that I last saw h alive on Oct 10 1948.

Immediate cause of death: Coronary Occlusion — Duration: 3 hours

Due to:

Due to: Chr Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature: Jay Jamison

Address: 2128 W North Ave Date signed 10/13/48

VS 15

Huntington Williams, M.D.

667502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 667502

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Residence

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3302 Burleith Ave, City (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Miss Zelda Lena Lipitz
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
f	white	Widowed

6 (b) Name of husband or wife Benjamin husband dead
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 15, 1877

8. AGE: Years	Months	Days	If less than one day
71	0	23	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Hyman Glauser (D)
13. Birthplace Russia

MOTHER
14. Maiden Name Rosa ? (D)
15. Birthplace Russia

16 (a) Informant daughter Mrs. Hyman Boyst
(b) Address 3302 Burleith Ave, Balt. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place
19 (a) (Date received by registrar) (b) Registrar

OCT 10 1948
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1948, at 10 08 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1948 to Oct 8 1948, and that I last saw h[er] alive on Oct 8 1948.

Immediate cause of death Generalized Carcinomatosis
Due to Ca of Sigmoid Bowel
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation Aug 16, 1948
Major findings of operation: Metastatic Carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
23. Signature John M. Dawson M.D.
Address Union Memorial Hos. Date signed 10/8/48 M.D.

G67503

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46D

G67503
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 C Abbots St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Lieberman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mamie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 5-27
8. AGE: Years 81 | Months | Days | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Bernard
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca
15. Birthplace Russia

16 (a) Informant Maryanna Lieberman
(b) Address 3506 Springdale Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew-Mt Carmel
18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eastern Place
19 (a) Date filed by registrar OCT 10 1948 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/48 19 at 7 55 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1948 to 10/8 1948, and that I last saw him alive on 10/8/48 19 10 A M

Immediate cause of death	Duration
Pulmonary edema	
Due to Congestive Heart Failure; Mesenteric thrombosis; Peritonitis	
Due to	
Other Conditions Carcinoma Rectum	

(Include pregnancy within 3 months of death)
Date of operation 9/27/48
Major findings of operation: Volvulus of Sigmoid Colon & Gangrene bowel
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature David V. Seltzer
Address Sinai Hospital Date signed 10/8/48

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G67504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

Registered No. 25504

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

(a) Baltimore City, Maryland

(b) Street address 5624 READY AVE

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town).

(d) Street No. 5624 READY AVE. (If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME SAMUEL L. BATEMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife ANN BATEMAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 5 1869

8. AGE: Years	Months	Days	If less than one day
79	10	3	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation SALESMAN

11. Industry or business

FATHER

12. Name SAMUEL BATEMAN

13. Birthplace MD.

MOTHER

14. Maiden Name ELIZABETH ROBINSON

15. Birthplace MD.

16 (a) Informant MARGARET E. BATEMAN

(b) Address 5624 READY AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10 11 48 (month) (day) (year)

(c) Cemetery or crematory CATHEDRAL

Location BALTO.

18 (a) Funeral director H.W. JENKINS & SONS CO.

(b) Address YORK RD. & ROSSITER AVE.

19 (a) OCT 12 1948 (b) [illegible] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 October 1948, at 5:30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 3 Oct 1948 to 8 Oct 1948, and that I last saw h[illegible] alive on 8 Oct 1948.

Immediate cause of death: Myocardial failure — Duration: 1 day

Due to: Arteriosclerosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature Howard [illegible] M.D.

Address 1515 N. Milton Ave Date signed 10-8-48

VS 150

667505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

667505 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument + Wolf Sts
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1539 Ramsay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Elizabeth Boughter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Late Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 18, 1874

8. AGE: Years	Months	Days	If less than one day
73	10	12	hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Wm Daub
13. Birthplace Penna

MOTHER 14. Maiden Name — Schaffer
15. Birthplace Penna

16 (a) Informant Mrs Bertha H Johnson
(b) Address 1539 Ramsay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11 48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Fredericksburg Penna

18 (a) Funeral director Harry H. Wilkes
(b) Address 4101 E Monument St

19 (a) OCT 1948 (Date rec'd by registrar) (b) Huntington Pl Baltimore, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1948, at 12 55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9 27 1948, to 10-8 1948, and that I last saw her alive on 10-8 1948.

Immediate cause of death	Duration
Subarachnoid hemorrhage	
Due to Arterial aneurism	
Due to	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Gaber, M. D.
Address Sinai Hosp Date signed 10-8-48

G667506

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G667506 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 39 days
(e) Length of stay in Baltimore (yrs., mos., or days): 39 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Fruitland
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Box 63
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Deal, George William

3 (b) If veteran, name war: VA 1

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 13, 1887

8. AGE:

Years	Months	Days	If less than one day
61	2	25	hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: truck laborer

11. Industry or business:

FATHER
12. Name: William Deal
13. Birthplace: unknown

MOTHER
14. Maiden Name: Hanna Wise
15. Birthplace: Snow Hill, Md.

16 (a) Informant: Records
(b) Address: U. S. Marine Hospital

17 (a) B. (Burial, cremation, or removal) **(b) Date thereof:** 10 - 11 - 48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Fruitland Md.

18 (a) Funeral director: James F. Stewart
(b) Address: Salisbury - Md.

OCT 10 1948

19 (a) (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8, 1948 at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30, 1948, to Oct. 8, 1948, and that I last saw him alive on Oct. 8, 1948.

Immediate cause of death	Duration
Carcinoma of bladder, advanced	6 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
Autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Clinical Director
Address: U.S. Marine Hospital Date signed: 10/8/48

667507

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

927

Registered No. 667507

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 Harlem Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Mc Roberts

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	c	W

6 (b) Name of husband or wife Mary L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Helen Reynolds
15. Birthplace Md

16 (a) Informant Helen L. Griffin
(b) Address 1615 Harlem Ave

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 10-1-48 (month) (day) (year)
(c) Cemetery or crematory Catonsville
Location Balto. Co.

18 (a) Funeral director Lemuel M. Sullivan
(b) Address 1011 N. Arlington Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1 1948 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1948 to Oct 1 1948, and that I last saw him alive on 10/1 1948.

Immediate cause of death	Duration
Acute Cardiac Dilatation	
Due to Chron. Myocardial Infarction	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address [illegible] Date signed 10/1/48

V S 150

467508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 467508

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens + Caton Aves.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)

(d) Street No. 2 Howard Ave. (If rural give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Gertheu Riggs

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4 Sex: Female

5 Color or race: White

6 (a) Single, married, widowed or divorced: Widowed

6 (b) Name of husband or wife: Uriah Ward Riggs

6 (c) If alive, give age: dec. years

7. Birth date of deceased (mo., day, yr): 9-21-1882

8. AGE: Years 66 | Months — | Days 18 | If less than one day: hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Daniel H. Crider (dec.)

FATHER — 13. Birthplace Pa.

MOTHER — 14. Maiden Name Mary Griggs (dec.)

MOTHER — 15. Birthplace Md

16 (a) Informant William W. Riggs

(b) Address 6 Howard Ave. Catons.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md.

18 (a) Funeral director Easton Sons

(b) Address 608 Frederick Ave. Caton

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 19 48 at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 19 48 to 10-9 19 48.

and that I last saw her alive on 10-9 19 48.

Immediate cause of death Cardiac failure — Duration

Due to Acute Coronary occlusion

Due to Arteriosclerotic c-v disease

Other Conditions

(include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Sidney J. Venable Jr MD M. D.

Address St Agnes Hospital Date signed 10/9/48

VS 150

BC-1948-3638 G67509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G67509

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3Days, 8Hrs., 15Min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore - 29,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4202 Potter Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Bernard Clatterbuck Jr.

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/5/48

8. AGE: Years | Months | Days: 3 | If less than one day: 8 hr. 15 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Bernard Clatterbuck
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Hazel Krause
15. Birthplace Pikesville Md.

16 (a) Informant Mrs Ida Clatterbuck
(b) Address 35 Greenspring Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Easton Bowie
(b) Address 608 Frederick Ave Catonsville

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION 12:15 A

20. DATE OF DEATH 10-9 19 48 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death: Pre-Mature Baby

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. S. Womack M. D.
Address Bon Secours Hosp. Date signed 10/9/48

VS 150

CERTIFICATE CORRECTED 9-1-60

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

667510 LCH 122441 — Registered No. 667510

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) Calverton
(d) Street No. 2319 Cloverton Hghts. Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY KRATZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/21/1870

8. AGE: Years 78 | Months 9 | Days 16 | If less than one day hr min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ? Weaver
13. Birthplace Maryland

MOTHER
14. Maiden Name Josephine Brown
15. Birthplace Md.

16 (a) Informant Balto. City Hosp. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Charles P Towell
(b) Address 1427 Edmondson Ave

19 (a) 10/4/48 (Date rec'd by registrar) (b) Registrar

10/9/48

V8 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7/48 19 at 1:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26/48 19 to 10/7/48 19, and that I last saw her alive on 10/7/48 19

Immediate cause of death: Acute Cardiac failure — Duration: 1 min.
Due to probable Myocardial infarction — 8 days.
Due to
Other Conditions: Fracture rt. hip — 6 weeks

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 16/5
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8-26-48 at 10:50 PM
(c) Where did injury occur? 2319 Calverton Hghts Ave (City or town) Baltimore (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury: fall & floor w/ hip fracture

23. Signature John L. Reichelt M. D.
Address Balto City Hosp Date signed 10-7-48

Approved by Dept. of Health Md

G67511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

G67511
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1322 W. Lexington St
(c) Hospital or institution:

19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 W Lexington St
(If rural give location)
20
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Berry Lee Bloxom

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
male	white	~~Sa~~

6 (b) Name of ~~husband~~ or wife Lannie Bloxom
6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr) May 21 - 1865

8. AGE: Years	Months	Days	If less than one day
85	4	18	hr. min.

9. Birthplace Bloxom Va.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Berry Bloxom
13. Birthplace Onancock Va.

MOTHER
14. Maiden Name Burnette Bloxom
15 Birthplace Va.

16 (a) Informant Mrs. L. L. Bloxom
(b) Address 1322 W. Lexington St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Bethel Baptist Church
Location Bloxom, VA.

18 (a) Funeral director Wm. J. Ticknor & Sons.
(b) Address Balto. Md. Huntington Millsboro, Md.

10 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 9 - 1948, at 7:00 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from 5-17-1948, to 10-9-1948, and that I last saw h~~im~~ alive on 10-2-1948.

Immediate cause of death Organic Heart Disease — Duration unknown

Due to

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at: M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester Ruland, M. D.
Address 2532 Edmondson Ave Date signed 10-9-48.

VS 150

667512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

667512 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edmondson Ave. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 Bolton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DAISY W. BAILEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 29, 1868

8. AGE: Years	Months	Days	If less than one day
80	7	9	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George W. Bailey
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Sarah Fite
15. Birthplace Unknown

16 (a) Informant Mrs. W. G. Bailey
(b) Address Route 5 Box 214 Woodlawn 7

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11 48 (month) (day) (year)
(c) Cemetery ~~Lochlarry~~ Wards Chapel
Location Baltimore County, Md.

18 (a) Funeral director, Wm. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) OCT 10 1948 (Date rec'd by registrar) Washington Millhouse, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1948, at 5:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 1948 to OCT. 8 1948, and that I last saw HER alive on OCT. 8 1948

Immediate cause of death ARTERIOSCLEROSIS — Duration ??

Due to

Due to

Other Conditions SENILITY ANEMIA — 3 MOS.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stuart D. Sunday M. D.
Address 201 E. 33rd St. Date signed 10/9/48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667513

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

667513 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3708 Egerton Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 Egerton Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CLARA MAY McLAUGHLIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 25, 1873

8. AGE: Years	Months	Days	If less than one day hr.	min.
75	4	13 14		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name Robert McLaughlin
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rebecca E. [illegible]dden
15. Birthplace Baltimore

16 (a) Informant Mrs. Robert M. Scheck
(b) Address 507 Yarmouth Rd., Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

OCT 9 1948 (b)
(Date rec'd by registrar) Registrar

VS 153

Transcription for Physicians Use

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1948, at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1948, to Oct 8 1948, and that I last saw h[illegible] alive on Oct 8th 1948

Immediate cause of death Acute Cardiac Asthenia — Duration 1½ hour

Due to Coronary Thrombosis — 9 days

Due to Hypertension — 9 years

Other Conditions Arterial Sclerosis — 2 years

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert E. Seipp M. D.
Address 3400 Windsor Ave Date signed 10/9/48

BC-48-420 2
667514

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

667514
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSON RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Univ. Hosp. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Adams.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-3-48

8. AGE: Years 0 | Months 0 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lester Adams
13. Birthplace Williamstown, Pa.

MOTHER
14. Maiden Name Catherine Bowman
15. Birthplace Williamstown, Pa.

16 (a) Informant Lester Adams
(b) Address 2431 Kennit St #3

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 10-10-48 (month) (day) (year)
(c) Cemetery or crematory Williamstown Pa.
Location

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) 10 1948 (b) Lexington Mkt. Registrar
Rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948 at 4 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1948 to Oct 8 1948, and that I last saw him alive on Oct 8 1948.

Immediate cause of death: Cardio-Resp. failure — Duration:
Due to Prematurity
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature David Auld
Address Univ. Hosp. Date signed 10/9/48

G67515 ✓ G67515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 313 Cathedral Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 313 Cathedral Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Margaret A. McElreavy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 8 / 1857

8. AGE: Years	Months	Days	If less than one day
81	2	7	hr min

9. Birthplace England
(Town, county, and state)

10. Usual Occupation

11. Industry or business Home - Duties

MOTHER / FATHER

12. Name Father, M. Elreavy

13. Birthplace Ireland

14. Maiden Name Jupiter Murphy

15. Birthplace Ireland

16 (a) Informant Miss Bessie C. McElreavy

(b) Address 313 S. Cathedral Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Old Orchard Road

18 (a) Funeral director Lake & Sons

(b) Address 1318 Light St.

19 (a) Date received by registrar (b) Registrar

Reporting to Baltimore

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948, at 2 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from 6-4 1938, to 10-8 1948, and that I last saw her alive on 10-7 1948.

Immediate cause of death Arteriosclerosis Cerebral vascular disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. Edmund Lewis

Address 3400 Hilton Rd Date signed 10/8/48

VS 150

667516

667516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3320 Virginia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Garret
(c) City or town Near Frederick (If outside city or town limits, write RFD and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Olivia M. Bowen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F
5. Color or race W.
6 (a) Single, married, widowed, or divorced W.
6 (b) Name of husband or wife J. Edward Bowen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 24, 1874

8. AGE: Years 74 | Months 0 | Days 18 | If less than one day: hr. 17 min.

9. Birthplace Roland Creek, Talbot Co., Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Thomas Morgan
13. Birthplace Roland Creek, Md.

MOTHER
14. Maiden Name Alzina Thomas
15. Birthplace Maryland

16 (a) Informant Mrs. Ida L. Bowen
(b) Address 3320 Virginia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Salisbury Methodist Church
Location Barnstown, Maryland

18 (a) Funeral director Young Funeral Home
(b) Address 3005 Park Heights Ave

OCT 11 1948 (Date rec'd by Registrar) (b) Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1948, at 6 P. M

21. I certify that death occurred on the date above stated that I attended deceased from June 1 1948 to Oct 9 1948 and that I last saw her alive on Oct 9 1948

	Duration
Immediate cause of death: Uraemia	7 days
Due to Hypertensive Cardiovascular Renal disease	2 yrs.
Due to Arteriosclerosis	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: none
of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Milton E. Lauman M. D.
Address 4643 Park Heights Ave Date signed 10/10/48
Oct. 10, 1948

667517

AZ-122751

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667517 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 [redacted] HOLLINS (St.) (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Steinbach

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. [redacted]

6 (b) Name of husband or wife Lillian Mills Steinbach
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr April 12-1887

8. AGE: Years 61 | Months 5 | Days 25 | If less than one day hr min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Truck helper

11. Industry or business Self-employed

FATHER
12. Name Charles Steinbach (D
13. Birthplace Germany

MOTHER
14. Maiden Name Mary McGary (D
15. Birthplace Ireland

16 (a) Informant Records, Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11 '48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Krause Funeral Home
(b) Address 216 S. Charles St.

19 OCT 11 1948 Huntington Williams M.D. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7. 1948 at 11.50 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 9-6- 1948 to 10-7 1948. and that I last saw him alive on 10-7 1948

Immediate cause of death Bilateral Pulmonary Tuberculosis — Duration 4½ mos

Due to

Due to

Other Conditions Malnutrition. Syphilis

(If female, pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Frank M. Shipley
Address Balto City Hosp. Date signed Oct. 12, '48

VS 153

12 12

G62518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. G62518

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 242 Mallow Hill Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 242 Mallow Hill Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer F. Orr

3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Lola M. Orr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1875

8. AGE: Years 73 | Months 4 | Days 18 | If less than one day: hr. min.

9. Birthplace Chicago, Ill. (Town, county, and state)
10. Usual Occupation Retired Insurance Agent
11. Industry or business Prudential Insurance Co.

FATHER
12. Name David F. Orr
13. Birthplace Maryland

MOTHER
14. Maiden Name Evelyn M. ?
15. Birthplace Maryland

16 (a) Informant Mr. William F. Orr
(b) Address Route 14, Box 322, Baltimore-20, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. W. Pearson
(b) Address 1003 E. Baltimore St.

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Funeral Director [illegible], M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1948 to Oct 8 1948, and that I last saw him alive on Oct 7 1948

Immediate cause of death: Myocarditis — Duration: Sudden

Due to: Arteriosclerosis

Due to: Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 4012 Edmondson Ave. Date signed

G67519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67519 ✓ Registered No. 124B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 27-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5600 Roland Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Giovanni Maria Fava

3 (b) If veteran, name war [redacted] (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Maria

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Jan 11th 1876

8. AGE: Years	Months	Days	If less than one day
72	8	24	hr. min.

9. Birthplace Italy (Town, county and state)

10. General Occupation Fruit Co Dealer

11. Name of employer Wine Co

FATHER 12. Name Andrew Fava

FATHER 13. Birthplace Italy

MOTHER 14. Maiden Name Nicoletta Limino

MOTHER 15. Birthplace Italy

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)

Cemetery Mausoleum Lorraine

Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1948, at 1 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 19 48 to 10/10 19 48

and that I last saw h alive on 19

Immediate cause of death: Cirrhosis of Liver, Primary hepatoma

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature Norman E Shamer M.D.

Address Johns Hopkins Hospital Date signed 10-10-48

VS 150

667520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

667520 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. TO correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Broadway
(If rural give location)
(e) Citizen of foreign country? Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-1-93

8. AGE: Years 55 | Months 11 | Days 8 | If less than one day: hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Stein
13. Birthplace Russia

MOTHER 14. Maiden Name Betty
15. Birthplace Russia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 15a

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Oct. 9, 1948, at 7 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1948 to Oct 9 1948.
and that I last saw h[illegible] alive on Oct 9 1948.

Immediate cause of death: Auricular fibrillation
Due to: Pulmonary edema
Due to: Interstitial and hypertensive heart disease.
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 1 day. / days. / years

Date of operation
Major findings of operation:
of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address J. H. H. Date signed 10-9-48

G67521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

Registered No. G67521

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1836 Harlem
(c) Hospital or institution: at Home 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 Harlem Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country China

3 (a) FULL NAME Rosalie Lee

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: Yellow
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lee Quong
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr) Oct-28-1894

8. AGE: (53) Years 54 | Months 11 | Days 10 11 | If less than one day: hr. min.

9. Birthplace China (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Not Known
13. Birthplace China

MOTHER
14. Maiden Name Not Known
15. Birthplace China

16 (a) Informant Mrs. William Lee
(b) Address 1435 E. Baltimore Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11 48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Stewart & Mowen Co.
(b) Address 108 W. North Ave, City #1.

19 OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8- 1948, at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11- 1948, to 10-8 1948, and that I last saw h[illegible] alive on 10-8 1948.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Ruland, M. D.
Address 2532 Edmondson Ave Date signed 10-9-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67522

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4416 Roland Ave
(c) Hospital or institution: at home 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4416 Roland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Milton Pawlet Hill

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Louisa B. Hill
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Sept-18-1884

8. AGE: Years 64 | Months 0 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business Medicine

FATHER
12. Name Dr Chas G Hill
13. Birthplace N.C.

MOTHER
14. Maiden Name Mabel Pawlet
15. Birthplace Balto. Md

16 (a) Informant Mrs Louisa B. Hill wife
(b) Address 4416 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-48 (month) (day) (year)
(c) Cemetery or crematory St Thomas'
Location Tamaon Forest

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. Mowen Sec.) 100 N. North Avenue

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Funeral for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1948, at 2.30 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from January 1948 to Oct 9 1948, and that I last saw him alive on Oct 8 1948.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William S Hopkins M.D.
Address 4006 Roland Ave Date signed Oct 9, 1948

VS 150

G67523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83D

Registered No. G67523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6313 Weidner Ave.

(c) Hospital or institution: Edgewood Nursing Home 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 7 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 6313 Meudner ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME McGINNISS, Mrs. Esther McGinniss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife William R. McGinniss

6 (c) If alive, give age About 65 years

7. Birth date of deceased (mo., day, yr.) June - 8 - 1868

8. AGE: Years	Months	Days	If less than one day
80	4	21	hr. min.

9. Birthplace Baltimore ? Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER

12. Name Uriah J. Bottomore

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Mary Louise Tregler

15. Birthplace Baltimore, Md.

16 (a) Informant Miss Katherine Bottomore

(b) Address 6313 Weidner Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-48 (month) (day) (year)

(c) Cemetery or crematory Presbyterian (Govans)

Location Baltimore, Md.

18 (a) Funeral director Stewart & Mowen Co.

(b) Address 108 West North Ave. Balto. Md.

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Interior Millinery MD (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9th 1948 at 6-40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 19 48 to Oct 9 1948, and that I last saw him alive on Sept 30 1948.

Immediate cause of death Intestinal Hemorrhage — Duration 15 min.

Due to Intestinal Lesion undetermined.

Due to

Other Conditions Hemiplegia — 5 yrs.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. E. Kaltman M. D.

Address 6710 York Rd Date signed Oct 12 '48

VS 150

123

667524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 667524

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1038 Sharp St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1038 Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Gracie Osborn

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/23/1881

8. AGE: Years 66 | Months 11 | Days 6 | If less than one day 15 hr. min.

9. Birthplace Marion Ala (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Bradford Clemons
13. Birthplace Ala.

MOTHER
14. Maiden Name Sallie Mart
15. Birthplace Ala

16 (a) Informant Thomas J Clemons
(b) Address 121 W Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. Co. Md

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 108 W Montgomery St

OCT 11 1948 (c) (Date received by registrar) (b) Twitchington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7/48 19 at 5 20 M

21. I certify that death occurred on the date above stated, that I attended deceased from April 15 1948 to Sept. 7 1948, 19
and that I last saw h alive on Oct. 7 1948.

Immediate cause of death: Chronic myocarditis — Duration 6 mo

Due to Chronic Interstitial

Due to Nephritis — 6 months

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lincoln Gleeton M. D.
Address 1038 Sharp St Date signed 10/11/48

VS 150

X

G667525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G667525 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) d.oa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 936 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES E. BETHEA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years	Months	Days	If less than one day
29			hr. min

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Neal E. Bethea
13. Birthplace S. C.

MOTHER
14. Maiden Name Bertha Campbell
15. Birthplace S. C

16 (a) Informant Pender Campbell
(b) Address 306 N. Fremont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-48 (month)
(c) Cemetery or crematory Dillon S. C.
Location S. C.

18 (a) Funeral director George B. Nelson
(b) Address 1303 Presstman ST

19 OCT 11 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1948, at 5 12 p. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 2nd & 3rd ° Burns of 50 % of body

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10- 8 -48 at Approx. 5 P. M.
(b) Where did injury occur? 936 Madison Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Room afire

23. Signature Emil L. Rogy M.D.
Medical Examiner.
Date signed 10-9-48

VS 151

X

667526

Medical Examiner's Case
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13

Registered No. 667526

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 680 Josephine St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Tilghman

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Isaac Tilghman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1894

8. AGE: Years 49 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Ida Tilghman
(b) Address 680 Josephine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location md

18 (a) Funeral director George B. Nelson
(b) Address 2303 Priestman St

19 OCT 11 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7- 1948 at 5:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1948, to 10-7 1948, and that I last saw h[illegible] alive on 10-1 1948.

Immediate cause of death: Pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

CERTIFICATION APPROVED BY
Thomas J. Mullen, M.D.
for H. R. Davis M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. F. Black M. D.
Address Provident Hosp Date signed 10-12-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G57527

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

LEH 122946

✓ 50

Registered No. 16[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Cherry Hill Road (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kate Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 8/22/1899

8. AGE: Years 49 | Months 1 | Days 16 | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Dallas Clayborn
13. Birthplace: Va.

MOTHER
14. Maiden Name: Mary Davis
15. Birthplace: Va.

16 (a) Informant: Records of Balto. City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-12-48 (month) (day) (year)
(c) Cemetery or crematory: Balto nat mal
Location:

18 (a) Funeral director: George S. Valsom
(b) Address: 1303 Pennsylvania Ave

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Funeral Director's Address: Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/7/48 19 . at 12:35 PM.

21. I certify that death occurred on the date above stated: that I attended deceased from 9/14/48 19 to 10/7/48 19 and that I last saw her alive on 10/7/48 19

Immediate cause of death: General Carcinomatosis. Duration: 2 yrs.

Due to: Carcinoma of the breast

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Robert Leglin M.D.
Address: BCH Date signed: 10-7-48

Leglin X

VS 150

667528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92c

667528 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1501 Battery Ave
(c) Hospital or institution:

24 41

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Battery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma E. Wicklein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife John N.
6 (c) If alive, give age 42 years
7. Birth date of deceased (mo., day, yr) July 25, 1909

8. AGE: Years	Months	Days	If less than one day
39	2	12	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Wilbur Wagner
13. Birthplace Md

MOTHER
14. Maiden Name Mary Hamilton Funk
15. Birthplace Md

16 (a) Informant Mrs Mary Wicklein
(b) Address 1501 Battery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Washington Blvd

18 (a) Funeral director John F Denny Inc
(b) Address 715 Light St

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1948 at 10 20 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1946 to Oct 6 1948 and that I last saw her alive on Oct 6 1948.

Immediate cause of death	Duration
Acute pulmonary Edema	3 hrs
Due to Chronic Cardiac Failure	1 yr
Due to Rheumatic Cardiovascular Disease	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 2704 Eastwood Date signed Oct 11 48

VS 150

667529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47 D

Registered No. 667529

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (Govanstown) (If outside city or town limits, write RURAL and give town)
(d) Street No. 4619 Ridgeway Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Rudiger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Gustavus Rudiger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 13, 1879

8. AGE: Years 69 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name John Wiseman

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Elizabeth Miller

15. Birthplace Balto Md

16 (a) Informant Mr. Gustavus Rudiger

(b) Address 4619 Ridgeway Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)

(c) Cemetery or crematory Western

Location Balto. Md.

18 (a) Funeral director Lasasha Funeral Home

(b) Address 740 Belair Rd.

19 OCT 11 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Oct 1948, at 6:39 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Sept 1948, to 9 Oct 1948, and that I last saw her alive on 9 Oct 1948.

Immediate cause of death Cachexia — Duration

Due to Carcinoma of Lung with

Due to generalized metastasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Carcinoma of Lung

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent A. Cacace M. D.

Address Franklin Square Hosp. Date signed 10 Oct 48

VS 150

667530 48-2033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

Registered No. 667530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga

(c) Hospital or institution: Mercy Hospital Inc.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 700 N. Montford (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Richard Ward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 29/48

8. AGE: Years: 0 Months: 0 Days: 11 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER 12. Name Benjamin S. Ward

13. Birthplace Baltimore

MOTHER 14. Maiden Name Ethel Schwartzkopf

15. Birthplace Baltimore

16 (a) Informant Mr. Benj. F. Ward

(b) Address 700 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 12 48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Philip Herwig Sons

(b) Address 2524 Orleans St

19 (a) OCT 11 1948 (Date filed by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10/48 1948 at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8 1948 to 10/10 1948. and that I last saw him alive on 10/10 1948

Immediate cause of death: Circulatory Collapse — Duration

Due to Scleroma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)

(e) Means of injury

23. Signature Joseph L. Agnetti M.D.

Address Mercy Hosp. Date signed 10/11/48

667531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

667531 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 - Division St.

(c) Hospital or institution: Provident Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 31 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RERAL and give town)

(d) Street No. 1727 - Madison Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Birdie Lewis Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married

6 (b) Name of husband or wife William Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 15, 1893

8. AGE: Years	Months	Days	If less than one day
55	1	23	hr. min.

9. Birthplace Matthews, Virginia (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant William Brown

(b) Address 1727 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Mt Auburn

Location Balto City

18 (a) Funeral director Wm A Jackson

(b) Address 916 Penna Ave

19 (a) OCT 11 1948 (Date rec'd by registrar) Thurlington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8- 1948, at 6 45 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 1948 to 10-8 1948 and that I last saw her alive on 10-8- 1948

Immediate cause of death	Duration
Cerebral Vascular accident probably thrombosis	
Due to Hypertension	
Due to	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Brady, M. D.

Address Provident Hosp Date signed 10-9-48

667532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

667532
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 N. Washington Street
(c) Hospital or institution:
Home 9-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 533 N. Washington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Merriken

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-14-0258

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name [redacted] wife Helena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec, 18-1884

8. AGE: Years	Months	Days	If less than one day
63	9	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Jacob Merriken
13. Birthplace Md.

MOTHER
14. Maiden Name Mary T. Gipprich
15. Birthplace Md ?

16 (c) Informant Francis Merriken
(b) Address 324 S. Lehigh Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-48 (month) (day) (year)
(c) Cemetery [redacted] Holy Rosary
Location Baltimore Co, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Funeral to be held at Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10th 1948, at 10:55 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1948, to Oct 10 1948, and that I last saw him alive on Oct 9 1948.

Immediate cause of death	Duration
Cerebral Softening	?
Due to Cerebral Thrombosis	
Due to Generalized Arteriosclerosis	
Other Conditions Acute Cerebral Rt. hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Leonard Bull M.D.
Address 1221 N. Luzerne Ave Date signed Oct 11 1948

821

667533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

667533 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3511 E. Fayette St D.O.A
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 4
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3511 E. Fayette St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Poos Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or divorced.
M	W	Married

6 (b) Name of ~~husband~~ or wife Bertha B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7th 1884

8. AGE: Years	Months	Days	If less than one day
64	5	-	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name John Poos Jr
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mrs. Bertha Poos
(b) Address 3511 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11th 1948 (month), (day), (year)
(c) Cemetery or ~~crematory~~ Laydon Park
Location Fredrick Road

18 (a) Funeral director Leo G. Cook
(b) Address 1201-03 N. Patterson Park Ave

OCT 11 1948 (Date rec'd by registrar) Funeral Home Williams, Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1948, at 5-20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease
Due to Arteriosclerotic Heart Disease
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. P. Schmidt M.D.
Medical Examiner.
Date signed 10/7/48

G67534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No. G67534

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The certificate, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2403 E. Federal St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 E. Federal St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Mirschberger

3 (b) If veteran, name war | 3 (c) Social Security Account No. 215-10-7731

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Irma E. Mirschberger 6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr) 4-6-1873

8. AGE: Years	Months	Days	If less than one day
70	6	3	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name John F. Mirschberger
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Catherine Holtz
15. Birthplace Germany

16 (a) Informant Irma E. Mirschberger
(b) Address 2403 E. Federal St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John C. Dilley Son
(b) Address 2435 E. Oliver St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9-1948 at M

21. I certify that death occurred on the date above stated: that I attended deceased from 12 Nov 1947 to 9 Oct 1948.
and that I last saw him alive on 9 Oct 1948.

Immediate cause of death Myocardial failure — Duration 10 days
Due to Hypertension
Due to Arteriosclerosis
Other Conditions Edema, Dyspnea
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marcus Fortman, M.D.
Address 1513 N. Monroe Date signed 11 Oct 48

VS 150

97

G67535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G67535 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 E Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Cooke

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Aubrey J. Cooke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-15-1914

8. AGE: Years 34 | Months 5 | Days 23 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Restaurant Owner

11. Industry or business

FATHER 12. Name Albert Clarke
13. Birthplace Md

MOTHER 14. Maiden Name Mary Franke
15. Birthplace Md

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Sec. Lot Grave

18 (a) Funeral director Miller & Leary
(b) Address 2425 E. Oliver St

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntingtown Hillcrest Md

MEDICAL CERTIFICATION 35

20. DATE OF DEATH Oct 8, 1948, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5, 1948 to Oct 8 1948 and that I last saw her alive on Oct 8 1948.

Immediate cause of death Undetermined — Duration

Due to Laennec's Cirrhosis of Liver

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Norman E Shaner
Address Johns Hopkins Hospital Date signed 10-8-48

VS 150

667536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20

667536 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 52 E. Hill Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 52 E. Hill Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Longo

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	

6 (b) Name of husband or wife Joseph Longo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4 - 1888

8. AGE: Years	Months	Days	If less than one day
60 (60)	9	5	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Marsiglia
13. Birthplace Italy

MOTHER
14. Maiden Name Marie Zito
15. Birthplace Italy

16 (a) Informant Mary Seppi
(b) Address 1256 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Road

18 (a) Funeral director Logal Funeral Dirs.
(b) Address 2013 Greenmount Ave

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1948 at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31, 1938 to Oct. 9, 1948, and that I last saw h alive on Oct. 2, 1948.

Immediate cause of death Hypertensive Cardio-Vascular disease
Mt Cardiac Hypertrophy
Brain and Dilatation
Concentric Fibrillation

Duration: 10 yrs. 3 days

Due to

Other Conditions Renal Tuberculosis — Duration: 10 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Medical Arts Bldg Date signed 10/11/48

939

67537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 67537

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 N. Greene St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Liberto

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Joseph Liberto

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1877

8. AGE: Years	Months	Days	If less than one day
71	4	25	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Pietro Danna
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12-1948 (month) (day) (year)
(c) Cemetery or crematory Mary Cathedral Cem
Location 4300 Old Frederick Rd

18 (a) Funeral director Joseph Fanaro Inc
(b) Address 2013 Belmont Ave

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Number 67537 (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1948, at 1150 P M

21. I certify that death occurred on the date above stated: that I attended deceased from Oct. 6 1948 to Oct 8 1948, and that I last saw her alive on Oct. 8 1948.

Immediate cause of death	Duration
Cerebro-vascular accident	3 days
Due to	
Due to	
Other Conditions Generalized arteriosclerosis Probable diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature T. Siwinski
Address Mercy Hosp. Date signed 10/14/48 M. D.

VS 150

83a

167538

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

Registered No. 167538

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution:
Home For Incurables 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks. 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life ~~11 yrs.~~

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss May Florence Gelletly

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 25 - 1886

8. AGE: Years	Months	Days	If less than one day
62	4	14 16	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Secretary (Painter)
11. Industry or business

FATHER
12. Name J. F. Gelletly
13. Birthplace Scotland

MOTHER
14. Maiden Name Emma M. Levette
15. Birthplace London, England

16 (a) Informant Charlotte Ettermann
(b) Address Home for Incurables (records)

17 (a) Cremation (b) Date thereof 10/12/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Crem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 11 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1948 at 9:35 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 8/20 1948 to 10/10 1948, and that I last saw h[illegible] alive on 10/9 1948

Immediate cause of death Metastatic Carcinoma to the brain — Duration 2 months

Due to Carcinoma of Right Breast — Duration 5 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation June 8, 1945

Major findings of operation: Primary Carcinoma of Right Breast.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hesperger M. D.
Address 214 Medical Arts Bldg. Date signed 10/10/48

VS 150

X

G67539

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G67539
Registered No.

The information should be carefully supplied. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md. (b) County Bal. Co.
(c) City or town Baltimore Hazelhurst
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5107 Leeds Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ida Christina Welden

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widowed
6 (b) Name of husband or wife Wm. Thomas Welden
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 12/8/1874

8. AGE: Years 23 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Walter Stahl (dec)
13. Birthplace Hanover Pa

MOTHER
14. Maiden Name Christina Minkel (dec)
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mary W. Hemberger
(b) Address 1505 Leeds Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICHNER & SONS
(b) Address Balto., Md.

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1948 at 5:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1948 to 10-9 1948.
and that I last saw h alive on 10-7 1948.

Immediate cause of death Cardio resp failure — Duration
Due to Arteriosclerotic c-v renal disease
Due to, or terminal uremia
Other Conditions Lobar pneumonia
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sydney J. Venable Jr MD M. D.
Address St. Agnes Hospital Date signed 10/9/48

Sydney J. Venable 121 a

667540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

GM. 122679

186a

667540 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside City or town limits, write RURAL and give town)
(d) Street No. 1302 W. Lexington ST. Nursing Home formerly of 831 Sucaw St.
(Usual residence)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret L. Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 11- 1862

8. AGE: Years	Months	Days	If less than one day
86	0	26	hr. min.

9. Birthplace MD.
(Town, county, or state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dennis Dorsey (D)
13. Birthplace MD.

MOTHER
14. Maiden Name Mary Carr
15. Birthplace Ireland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/12/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catheiral Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 11 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10- 7- 1948 at 3.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9- 3- 1948 to 10- 7- 1948.
and that I last saw her alive on 10- 7- 1948

	Duration
Immediate cause of death Cerebro vascular accident	1 wk
Due to Broncho - Pneumonia	
Due to	
Other Conditions Left hip fracture of fem.	6 wks
Date of operation 9/15/48	
Major findings of operation: Fracture of femur	
of autopsy:	

CERTIFICATION APPROVED BY
Howard J. Hawkins M.D.
For C.P.J. Lubinski M.D.
CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide, or homicide~~ 12/2
(b) Date of occurrence 20 Sept. at M
(c) Where did injury occur? Balto. Balto. Md.
(City or town) (County) (State)
1324 W. Lexington St.
(d) Did injury occur about home, on farm, industrial place, in public place? On Street While at work? no
(Specify type of place)
(e) Means of injury Fell while walking

23. Signature C. Wiseman M. D.
Address Balto. City Hosp. Date signed 10/7/48

VS 150

To Be Approved By Med. Examiner.

667541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

667541 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1836 Mc Culloh St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1836 Mc Culloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beauford Hector Jones.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Nannie Jones.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 12, 1878

8. AGE: Years 70 Months - Days 26 If less than one day hr. min.

9. Birthplace Perry, Ga.. (town, county, and state)

10. Usual Occupation Retired Pullman Porter

11. Industry or business

FATHER 12. Name John Wilson Jones.

13. Birthplace Ga..

MOTHER 14. Maiden Name Margaret Bass.

15 Birthplace Ga.

16 (a) Informant Nannie Mitchell.

(b) Address 1836 Mc Culloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 11, 1948. (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Mrs Kate R Williams

(b) Address 322 N. Schroeder St.

19 (a) OCT 11 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 8 1948 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1948 to 10-8 1948 and that I last saw him alive on 10-8 1948.

Immediate cause of death	Duration
Myocardial Degeneration	1 mo.
Due to	
Due to	
Other Conditions Fell Sept. Item plural.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Ramsey Duckett M. D.

Address 1547 Bloom St Date signed 10/9/48

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G67542

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE INDELIBLE PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 828 W. Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 828 W. Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Jenkins.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Lillie Jenkins.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 30, 1892

8. AGE: Years	Months	Days	If less than one day
56	6	9	hr. min.

9. Birthplace Cambridge, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Jenkins
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza /
15. Birthplace Md.

16 (a) Informant Lillie Jenkins.
(b) Address 828 W. Franklin St

47 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948, at 4 15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1948 to Oct 8 1948, and that I last saw him alive on Oct 8 1948.

Immediate cause of death Pulmonary edema, Acute Congestive Heart Failure (Dt)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: Approx. 4 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature H. Garland Chinault M.D.
Address 902 W Franklin St Date signed 10-10-48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667543 (also 537543)

163H

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 8207 Dundalk Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES LEROY McCORMICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen V. Dembeck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1912

8. AGE: Years 36 | Months 2 | Days 12 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James P. McCormick
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ella L. Long
15. Birthplace Balto. Md.

16 (a) Informant: Wife
(b) Address 8207 Dundalk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48
(c) Cemetery or crematory Baltimore Cemetery
Location North Ave. & Rose St.

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 N. Broadway

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1948, at 3 P. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to
Illuminating gas

Due to

Other Conditions Mental Despondency
(Include pregnancy within three months of death)

22. If an external cause was [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury 10-8-48 Approx. at 2:25 P. M.
(b) Where did injury occur? 8221 Dundalk Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Inhalation of illum. gas (4 burners of gas range on unlit gas heater on but unlit

23. Signature M.D.
Medical Examiner.
Date signed 10-9-48

Please write plainly, with indelible ink. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667544 DC. 658817

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

122a

667544 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1642 Mountman Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MELVIN AMPREY

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife ---

6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) October 9, 1946

8. AGE: Years 1 | Months 23 11 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Amprey
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Marion Jackson
15. Birthplace Mafyland

16 (a) Informant: Records
(b) Address Johns Hopkins Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11 1948 (month) (day) (year)

(c) Cemetery or crematory Mount Calvary
Location Brooklyn

18 (a) Funeral director Joseph Russ
(b) Address 12 [illegible] Mc [illegible] St.

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1948 at 12:35 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Respiratory failure due to administration of anesthesia

Due to

Other Conditions hernioplasty
Thoractotomy
(Include pregnancy within three months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-7-48 at 11:45 A. M.
(b) Where did injury occur? Johns Hopkins Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? hospital (Specify) No
(d) Means of injury Died on operating table-- given ether

23. Signature [signature] M.D.
Medical Examiner.

Date signed 10-9-48

667545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

667545 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 Lyndhurst Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ramey Harry M. (Harry M. Ramey)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-14-9858

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Sallie Zea Ramey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 23, 1874

8. AGE: Years	Months	Days	If less than one day
74	7	16	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation retired Banker
11. Industry or business

FATHER
12. Name James Madison Ramey
13. Birthplace Va.

MOTHER
14. Maiden Name Christine Ann Funk
15. Birthplace Md.

16 (a) Informant: Edward J. Ramey
(b) Address 3603 Gwynns Falls Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave, Baltimore, Md

19 (Date received by Registrar) OCT 11 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1948 at 6 45p M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1948 to Oct 9 1948, and that I last saw him alive on Oct 9 19 48.

Immediate cause of death	Duration
Gastro-intestinal Hemorrhage, Anemia	
Due to Duodenal + gastric ulcer	
Due to	
Other Conditions Rheumatic C. Disease B.P.H.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Hemorrhagic cardiac enlargement, arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Jos Shea
Address Univ. Hosp. Date signed 9 M 49

Joseph Shea X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667546

LCH 121322

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 84 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Chapel Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MaryRose

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/25/1888

8. AGE: Years	Months	Days	If less than one day
59	10	12	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Valentine Schwieger
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Dunnigan
15. Birthplace Maryland

16 (a) Informant Records of Balto. City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus cemetery
Location Mt. Dundalk Ave. Baltimore

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 South Wolfe St. Baltimore

OCT 11 1948 (Date received) (b) (Registrar) Huntington Williams, M.D.

STATE VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/48 19 . at 0935 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6 1948 to 10/8 19 48.
and that I last saw her alive on Oct 8 19 48.

Immediate cause of death: Resp + Cardiac failure — Duration

Due to Ant. Sol. C.V. Disease + Brain edema

Due to Pul Fibrosis Exfoliative

Other Conditions Diabetes Chr. Syphilis (Tbc.)
Hypertension Mastoiditis
(Include pregnancy within 3 months of death)

Date of operation 10-6-48

Major findings of operation: Adhesions Exudates Edema

of autopsy: Inflammation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis T. Mangiaracina M. D.
Address 614 Druid Pk. Date signed 10/6

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Thomas White

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 D

Registered No. 167547

167547

Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 338 East 22nd Stre
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 338 East 22nd Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HUGH FRANCIS COYLE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Harrietta M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Steamship Co.

FATHER
12. Name Bernard Coyle
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Cole
15. Birthplace Pa.

16 (a) Informant Mrs. Harrietta M. Coyle
(b) Address 338 East 22nd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location City.

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22nd ST.

19 (a) OCT 11 1948 (Date rec'd by registrar) Huntington Hollins

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/48 19 at 6.30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 8 hours 19 48 to 10/8 19 48 and that I last saw him alive on 10/7 19 48

Immediate cause of death: Myocardial infarction — Duration 2 days

Due to: Coronary thrombosis — 5 yrs

Due to: Arteriosclerosis — 5 yrs

Other Conditions: High blood pressure — 5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23) Signature Thomas F White M. D.
Address 522 E 22nd St Date signed 10/9/48

VS 150

67548 Bna 2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67548

469

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Hacks Neck (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frank R. Read
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1-2 05
8. AGE: Years 43 | Months 8 | Days 18 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Writer
11. Industry or business

FATHER
12. Name James Rogers Read
13. Birthplace Md

MOTHER
14. Maiden Name Lillie Collins
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)
(c) Cemetery or crematory GREENMOUNT Cem. City
Location

18 (a) Funeral director WIEDEFELD
(b) Address GREENMOUNT AVE & 22nd ST.

OCT 11 1948 (Date rec'd) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1948 at 1:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1948 to 10-8 1948 and that I last saw him alive on 10-8 1948.

Immediate cause of death: Carcinoma of pancreas — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature John Grant Wilmer M D
Address Johns Hopkins Date signed Oct 8, 48

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67549

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. 67549

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 CHAPEL GATE LANE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 CHAPEL GATE LANE (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME MADALINE DI GRISTINE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife CARMELO DIGRISTINE
6 (c) If alive, give age Dec years

7. Birth date of deceased (mo., day, yr) DEC. 5 1887

8. AGE: Years	Months	Days	If less than one day
60	10	3	hr. min.

9. Birthplace ITALY (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry/or business AT HOME

FATHER
12. Name JOSEPH JARDINIA
13. Birthplace ITALY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ITALY

16 (a) Informant MRS. THOMAS FARRAR
(b) Address 16 N. POSSUTH STREET

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 12/48 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BALTIMORE MARYLAND

18 (a) Funeral director F.P.WIPPERT & SON
(b) Address 1300 EUTAW PLACE. 17

19 (a) OCT 11 1948 (Date rec'd by registrar) Lucretia Worthington Mc Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH OCTOBER 8th 1948 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4 1948 to 10/8 1948.
and that I last saw her alive on 10/8 1948.

Immediate cause of death: Acute Cardiac Collapse — Duration: 1 Da
Due to: Diabetic Retinitis — yrs
Due to: Hypertension Cardiovascular Disease — yrs
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 1 WASHINGTON BLVD Date signed

VS 133

667550

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 6675.0

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway and Fairmount Ave
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 167 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 W. Baltimore Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie J. Braun

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife George William Braun
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) January 4, 1898

8. AGE: Years 50 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Fortifer
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Eckert
15. Birthplace Maryland

16 (a) Informant Hazel Anderson
(b) Address Church Home and Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 Oct. 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore - Md

18 (a) Funeral director H. B. Shepherd & Son
(b) Address 1300 Eutaw Place

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Thomas Wilson, Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948, at 12.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1948 to Oct. 8 1948, and that I last saw her alive on 10-8 1948.

Immediate cause of death	Duration
(a) Cardiac failure - atrophy of pancreas - Diabetes mellitus	
Due to (b) Fatty cirrhosis of liver	
Due to (c) Bilateral pleural effusion	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Church Home Date signed 10/8/48

WHITE PAPER, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G67551

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3107 OTTAWA AVE.
(c) Hospital or institution: ********** 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) **
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE. MORRELL PARK (If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 OTTAWA AVE (If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No) If yes, name country

3 (a) FULL NAME BASIL M. HILTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife MIRIAM HILTON
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr) MARCH 19-1862

8. AGE: Years	Months	Days	If less than one day
86	6	18	hr. min.

9. Birthplace ELLICOTT CITY Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name JAMES C. HILTON
13. Birthplace MARYLAND

MOTHER
14. Maiden Name SARAH MULLINEAUX
15. Birthplace MARYLAND

16 (a) Informant MRS. JOHN XYLANDER
(b) Address 4226 FALLS ROAD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 OCT. 48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 EUTAW PLACE....17

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Thurlington for Williams, M.

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 7TH. 1948 at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Oct 1948 to 7 Oct 1948. and that I last saw him alive on 7 Oct 1948.

Immediate cause of death: Cardiac failure and decompensation — Duration: Indefinite
Due to Arteriosclerosis and hypertensive cardio vascular disease
Due to (marasmus)
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emil W Henning M.D.
Address 4580 Edmondson Ave Date signed 10 Oct 48.

VS 150

667552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 937

667552 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 E West St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 E. West St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha F. Sachuk

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Married

6 (b) Name of husband or wife Pawel Sachuk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10. 1889

8. AGE: Years	Months	Days	If less than one day
59	7	29	hrs. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ? Grudska
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Pawel Sachuk
(b) Address 24 E. West St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem. Location G. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St

19 (a) OCT 11 1948 (Date rec'd by Registrar) Huntington for Hillcoat, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1948. at 7:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5, 1948. to Oct. 9, 1948. and that I last saw h[illegible] alive on Oct. 7, 1948.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	
Due to	
Due to	
Other Conditions Generalized edema. —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. R. Friedman M.D.
Address 1319 Light St. Date signed 10/11/48 M. D.

VS 153

G67553

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

G67553
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2223 E. Pratt. St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2223 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Markiewicz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Michael
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 26 - 1870

8. AGE: Years	Months	Days	If less than one day
78	8	15	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Rulewicz
13. Birthplace Poland

MOTHER
14. Maiden Name Mary
15. Birthplace Poland

16 (a) Informant Cecilia Markiewicz
(b) Address 2223 E. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location A. A. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 (a) OCT 11 1948 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 10 19 48 at 10 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT. 29 19 48 to OCT. 10 19 48 and that I last saw her alive on OCT. 10 19 48.

Immediate cause of death	Duration
(a) CORONARY Occlusion	10/10/48
Due to ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR DISEASE	???
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Delugas M. D.
Address 209 E. Chase St Date signed 10/11/48

VS 150

G67554 91382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12

Registered No. G67554

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1021 W. 37th St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Thelma Marie Clatterbuck

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Arbra W. Clatterbuck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1915

8. AGE: Years	Months	Days	If less than one day
32	11	26	hr. min.

9. Birthplace Md. Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name James Gover McCartin

13. Birthplace Md.

MOTHER

14. Maiden Name Ruth Ethel Burgee

15. Birthplace Md.

16 (a) Informant B.C.H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13, 1948 (month) (day) (year)

(c) Cemetery or crematory Moreland Memorial Park

Location Baltimore Co., Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) OCT 11 1948 (Date rec'd by registrar) Lentington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1948 at 11.30 Am

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2, 1945 to Oct. 10 1948. and that I last saw her alive on Oct. 10 1948

Immediate cause of death	Duration
Far advanced bilateral pulmonary tuberculosis with cavitation	3 yr. 9 mo.
Due to Ulcerative pleurisy bilateral with organized	2 years
Due to Emphysema right	
Other Conditions Hepatomegaly. Splenomegaly & mo. enlarged kidneys Tbc pancreatitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)

(e) Means of injury

23. Signature Margaret A. Morgan M. D

Address Baltimore City Date signed 10-12-48

VS 155

667555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

667555 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33[illegible] Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 36 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3619 Falls Rd. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Roy Calvin Derry.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-01-1181

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thelma Derry.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr) April 14th 1889

8. AGE: Years 49 | Months 5 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Trucker.

11. Industry or business Furniture Transfer & Storage Co.

FATHER
12. Name Lawrence Derry
13. Birthplace W. Va.

MOTHER
14. Maiden Name Julia Grove.
15. Birthplace W. Va.

16 (a) Informant Roy C Derry.
(b) Address 3619 Falls Rd, Balt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12-1948 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Oct 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1948, at 1045 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1948 to Oct 9 1948, and that I last saw him alive on Oct 9 1948.

Immediate cause of death: Coronary Thrombosis & Myocardial Infarction — Duration 14d.

Due to: Arteriosclerosis

Due to:

Other Conditions: Mural Thrombosis, Old Myocardial Infarction (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Brown M.D.
Address Univ. Mem. Hosp. Date signed 10-9-48 M.D.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67556

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c ✓ G67556 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Garden Apts (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Bertram S. Rice (Bertram S. Rice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Widower

6 (b) Name of ~~husband or~~ wife Cecelia M. Rice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1884

8. AGE: Years	Months	Days	If less than one day
63	10	20	hr. min.

9. Birthplace Colorado (Town, county, and state)
10. Usual Occupation Prop. Dress Shop
11. Industry or business

FATHER
12. Name Solomon Rice,
13. Birthplace Germany

MOTHER
14. Maiden Name Hannah Nordlinger,
15. Birthplace Germany.

16 (a) Informant Mrs Bertram L. Rice
(b) Address 3907 Fordleigh Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Ohel Shalom Cem
Location Balto. Md.

18 (a) Funeral director Abrid Sonneborn & Sons
(b) Address 202 Eutaw Place

19 OCT 11 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 – 10 – 1948 at 5:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9- 1948 to 10-10- 1948, and that I last saw h~~im~~ alive on 10-10- 1948.

Immediate cause of death	Duration
Pulmonary edema	
Due to Cardiac decompensation	
Due to Acute myocardial infarction	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address Sinai Hospital Date signed 10-10-48

VS 150

G67557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G67557

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3711 Liberty Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 8
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Liberty Heights Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LENA GOLANER ROSENSTEIN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Louis Rosenstein.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 1872.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76	6			

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Simon Golaner,
13. Birthplace Poland.

MOTHER
14. Maiden Name Anna Furstenberg,
15. Birthplace Poland.

16 (a) Informant Mr. Albert Rosenstein,
(b) Address 3711 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10.11.48. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Bernard Lowenstein & Sons
(b) Address 1902 Eutaw Place.

19 (a) OCT 11 1948 (Date rec'd by registrar) Huntington Williams Jr.

MEDICAL CERTIFICATION P

20. DATE OF DEATH Oct. 10th. 1948 at 7.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 24 1948 to Oct 10 1948, and that I last saw h[illegible] alive on Oct 5 1948

Immediate cause of death	Duration
Coronary Thrombosis	1 hr.
Due to	
Due to	
Other Conditions Coronary artery disease: Heart Attack. (Include pregnancy within 3 months of death)	1 mo.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irwin Gantz M. D.
Address 3003 Garrison Blvd. Date signed 10-11-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

667558

Registered No. 667558

667558

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE WHITE PAPER, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 215 N Milton ave

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 215 N Milton ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lillie Kelso

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife John L Kelso

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10 [illegible]

8. AGE: Years	Months	Days	If less than one day
60	-	29	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER

12. Name Leo Smith

13. Birthplace Balto

MOTHER

14. Maiden Name Mary Walsh

15. Birthplace Balto

16 (a) Informant Mrs J Kelso

(b) Address 503 N Robinson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12 (month) (day) (year)

(c) Cemetery or crematory Balto Cem

Location

18 (a) Funeral director Leavitt Funeral Home

(b) Address 200 E Orleans St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

OCT 11 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9 1948, at 11 15 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-6 1948 to 10-9 1948, and that I last saw her alive on 10-9 1948.

Immediate cause of death	Duration
Arteriosclerotic heart disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jerome Graber M. D.

Address Sinai Hosp Date signed 10-9-48

6675:59

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 6675:59

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.A.H.
(b) Street address
(c) Hospital or institution: 1101 N. Luzerne Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 N. Luzerne Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa A. Novak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct ? 1867

8. AGE: Years 80 Months Days If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business At home

FATHER
12. Name John Novak
13. Birthplace Austria

MOTHER
14. Maiden Name Anna Kadan
15. Birthplace Austria

16 (a) Informant Lena Novak
(b) Address 1101 N Luzerne Ave

17 (a) Burial (b) Date thereof Oct 12th 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director Welsh Funeral Home
(b) Address 2108 Orleans St

19 (a) OCT 11 1945 (b) Funeral Director
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9 1945 at 1:20 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions Func. Cirrhosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work)
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 10/9/45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The [illegible] of information should be carefully supplied. The

G67560

BALTIMORE CITY HEALTH DEPARTMENT

Nies

CERTIFICATE OF DEATH

95c

G67560 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2218 Orleans St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Nies

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Helen Nies

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26 - 1874

8. AGE: Years 64 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business Upholstery

FATHER 12. Name Joshua R Nies

FATHER 13. Birthplace Balto

MOTHER 14. Maiden Name Matilda Cohen

MOTHER 15. Birthplace Balto

16 (a) Informant Helen Nies

(b) Address 2218 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13 (month) (day) (year)

(c) Cemetery or crematory Balto Cem

Location City

18 (a) Funeral director Ulrich Funeral Home

(b) Address 1800 E Orleans St

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10- 1948, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10- 1948 to 10-10- 1948, and that I last saw him alive on 10-10- 1948.

Immediate cause of death Pulmonary edema — Duration

Due to Cardiac decompensation

Due to Acute myocardial infarction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Is about

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature

Address Sinai Hospital M. D. Date signed 10-10-48

VS 150

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67561

476918

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46 B

Registered No. G67561

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town St. Petersburg, (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 James, Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Vincze

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-18-77

8. AGE: Years	Months	Days	If less than one day
70	10	22	hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Steve Vincze
13. Birthplace Hungary

MOTHER
14. Maiden Name Susan Toth
15. Birthplace Hungary

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 12 (month) (day) (year)
(c) Cemetery or crematory St Petersburg Florida
Location

18 (a) Funeral director Ullrich Funeral Director
(b) Address 2005 Arlington Ave

19 (a) (Date rec'd by registrar) (b) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1948 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7- 1948 to 10-10 1948 and that I last saw h in alive on 10-10- 1948.

Immediate cause of death Carcinoma of stomach with metastasis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Oct 1948
Major findings of operation Ca of stomach with metastasis
of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Henry T. Bahnson
Address JHH
Date signed 10/11/48 (M) (D)

X

Dr. Sawyer

667562

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667562

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4502 Mainfield Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4502 Mainfield Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Beck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Johanna A. Beck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 30, 1887

8. AGE: Years	Months	Days	If less than one day
61	3	10	hr. min.

9. Birthplace Chicago, Illinois
(Town, county, and state)
10. Usual Occupation Analyst Kopper Corp.
11. Industry or business

FATHER
12. Name Gustav Louis Beck
13. Birthplace Germany

MOTHER
14. Maiden Name Carolina Albravid
15. Birthplace Wisconsin

16 (a) Informant Mr. Wm. H. Beck, Jr.
(b) Address 4502 Mainfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) OCT 11 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1948 at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1947 to Oct 10 1948 and that I last saw h/M alive on Oct 9 1948.

Immediate cause of death	Duration
acute coronary Occlusion	1 day
Due to Arteriosclerotic Heart Disease	7 years.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Dunigan M. D.
Address 4808 Harford Rd. Date signed 10/11/48

VS 150

Every item of information should be carefully supplied. Physicians; please write the causes of death clearly and legibly. correct age is especially important.

G67563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157B

Registered No. G67563

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2525 Kentworth Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Metzger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fe.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 9, 1948

8. AGE: Years | Months | Days | If less than one day: 22 hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Infant

11. Industry or business

FATHER
12. Name: Mirvin Henry Metzger
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Mildred Helena Meyers
15 Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. M. H. Metzger
(b) Address: 2525 Kentworth

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balto

18 (a) Funeral director: J. J. Luck
(b) Address: 5305 Raiford Rd

19 (a) OCT 11 1948 (Date rec'd by registrar) (b) Huntington Hollins, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1948, at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8/ 1948 to 10/9/ 1948 and that I last saw her alive on 10/8/ 1948.

Immediate cause of death: Respiratory failure — Duration: 1 hr.
Due to: Prematurity
Due to: Cervical Agenesis
Other Conditions: Bronchopneumonia, bilateral
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature: James S. Hoard, M.D.
Address: St. Josephs Date signed 10-9-48

Direct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 667564

667564

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cleveland & Raymond St.
(c) Hospital or institution:
West Balt Jewish Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore 14 Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7802 Clarkwood Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Riley A. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20th 1864

8. AGE: Years 84 | Months 0 | Days 19 | If less than one day 11 hr. 30 min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Retired Grocerymans

11. Industry or business

FATHER
12. Name Don Carlos Miller
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Emma Miller
(b) Address 7802 Clarkwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Kuck
(b) Address 5305 Harford Rd.

19 (a) OCT 11 1948 (Date rec'd by registrar) Dentist in Baltimore City

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9th 1948, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 1948, to October 9th 1948, and that I last saw him alive on October 9th 1948.

Immediate cause of death Myocardial failure — Duration

Due to Arteriosclerotic Cardio-vascular Heart Disease

Due to

Other Conditions Intestinal Obstruction

(Include pregnancy within 3 months of death)

Date of operation 9/24/48; 10/4/48

Major findings of operation: Large & Small bowel obstruction.

of autopsy: Mod. Adv., Ca of colon, peritonitis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howe Linn Grant M. D.

Address Date signed

VS 150

PRINT WITH PENCIL, WITH ONE CARBON. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

669565 V 669565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 929

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6727 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
20
(d) Street No. 6727 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Gompf

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Lillie J. Gompf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21. 1859

8. AGE: Years	Months	Days	If less than one day
89	11	20	hr. min.

9. Birthplace Balto. Co. (Town, county, and state)
10. Usual Occupation Retired gardener
11. Industry or business

FATHER
12. Name Peter Gompf
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Lillie J. Gompf
(b) Address 6727 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto. Co.

18 (a) Funeral director J. F. Cline & Sons
(b) Address Reisterstown, Md.

19 Oct 13 1948 (b)
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1948, at 4- P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 23, 1945, to Oct. 11 1948, and that I last saw him alive on Oct. 11, 1948.

Immediate cause of death	Duration
Coronary Occlusion	Sudden
Due to Chronic Myocarditis	?
Due to Arterio Sclerosis and Senility	?
Other Conditions Cerebral hemorrhage December 1945	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. E. Nichols M.D.
Address Pikesville-8 Md. Date signed 10/12/48

VS 150

A 67566

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

A 67566 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3519 Denison Rd.
(c) Hospital or institution: 2841
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3617 Woodbine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE PFAFF

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Henry V. Pfaff
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Apr. 5, 1868
8. AGE: Years 80 | Months 6 | Days 7 | If less than one day hr. min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name John Krausz
13. Birthplace Baltimore

MOTHER
14. Maiden Name Weller
15. Birthplace

16 (a) Informant Mrs. H. H. Vogel
(b) Address 2519 Denison Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICHNER & SONS
(b) Address Balto., Md.

OCT 13 1948 (b) [illegible] (Deputy) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1938 to 10-12 1948, and that I last saw h[illegible] alive on 10-12 1948.

Immediate cause of death: Arteriosclerosis Hypertension Diabetes — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 10/13/48

VS 153

Physicians: please write the causes of death clearly and legibly. Postage is especially important.

Dr John A. Lutcher
667357 Eager 57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. 667357

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 McKeon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 McKeon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Hildebrandt

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife Nellie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 14 1883

8. AGE: Years	Months	Days	If less than one day
65	6	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles H Hildebrandt
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna C. Hampel
15 Birthplace Baltimore

16 (a) Informant Betty Jo Hildebrandt
(b) Address 426 Graystone Terrace

17 (a) Remove (Burial, cremation, or removal) (b) Date thereof 10/11/48 (month) (day) (year)
(c) Cemetery or crematory Mt Hebron Cem
Location Winchester Va

18 (a) Funeral director Wm Cook Inc.
(b) Address 1216 [illegible]

19 [illegible] Entered by [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1948, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1923, to Oct 11 1948, and that I last saw h alive on Oct 11 1948.

Immediate cause of death: Cancer of Lung + metastasis to Brain — Duration: Known 6/15/48
Due to
Due to
Other Conditions Myocardial Insufficiency — 2 yrs
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature Jno A Lutcher M. D.
Address 12 E Eager St (Balto 2) Date signed Oct 11/48

VS 150

Physician's age is especially important. Physicians: please write the causes of death clearly and legibly.

G67568

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 50

Registered No. G67568

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 St. Paul St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Roberta Ann Ashcom

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) October 15, 1884

8. AGE: Years	Months	Days	If less than one day: hr.	min.
63	11	25		

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John L. Ashcom
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Robert Ann Bean
15. Birthplace Baltimore, Md

16 (a) Informant Nellie F. Collison
(b) Address 3120 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.
Washington Williamson, Agt

19 (a) [illegible] (To be filled in by registrar) Registrar

12 [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1948, at 6:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8 1948, to 10-10 1948, and that I last saw her alive on 10-10 1948.

Immediate cause of death	Duration
Metastatic carcinoma of lung & dura	
Due to Generalized carcinomatosis, abdomen &	
Due to Carcinoma, left breast	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Beamon P. Brown, M.D.
Address Union Memorial Hospital Date signed 10/11/48

Age is especially important. Physicians: please write the causes of death clearly and legibly. The

667569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

667569 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2405 Annor Court.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2405 Annor Court
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Ellsworth Linton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Bessie Linton

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Jan-25-1885

8. AGE: Years 63 | Months 8 | Days 16 17 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Fireman (retired)

11. Industry or business

12. Name James W. Linton

13. Birthplace Baltimore

14. Maiden Name Elizabeth Goodman

15. Birthplace Baltimore

16 (a) Informant Mrs. Bessie Linton

(b) Address 2405 Annor Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)

(c) Cemetery Meadow Ridge

Location Dorsey Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) Filed by registrar Washington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1948 at 9 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Oct-11-1948, and that I last saw h[illegible] alive on October-11-48

Immediate cause of death

Cancer of the lung — Duration about 16 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Biopsy of Aug. 48

Major findings of operation: Cancer of left lung, metastases in [illegible] of autopsy:

PHYSICIAN

(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter H. Sonnenfeldt M.D.

Address 2708 Hollins Ferry Rd Date signed 10/14/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. 67570

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1630 Darley Ave.
(c) Hospital or institution: [illegible]

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Darley Ave (If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Walker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Martha Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 79 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business Revenue Officer

FATHER
12. Name Geo Walker
13. Birthplace Baltimore

MOTHER
14. Maiden Name [illegible]
15. Birthplace Balto

16 (a) Informant Mrs Mary Thomas
(b) Address 1630 Darley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Aliceanna St

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 12 1948

Huntington Pathological Lab

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1948, at 3 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1948 to Oct 9 1948 and that I last saw him alive on Oct 8 1948

Immediate cause of death: Cardiac Decompensation — Duration Oct 8/48

Due to

Due to

Other Conditions: Chronic Hypertension (arteriosclerosis) — a number of years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norris B. Green M. D.
Address 3009 Eastern Ave Date signed 10/11/48
Baltimore 14 Md.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667571

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97

667572 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3704 Overview Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3704 Overview Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Mondschein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Katie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 81 | Months | Days | If less than one day: hr. min.

9. Birthplace Hungary (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name not known
13. Birthplace Hungary

MOTHER
14. Maiden Name not known
15. Birthplace Hungary

16 (a) Informant Eugene Mondschein
(b) Address 3708 Overview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Kenty Inc
(b) Address 2106 Eastern Place

OCT 12 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11 1948, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1948 to 10/11 1948.
and that I last saw h/M alive on 10/11 1948.

Immediate cause of death: acute enterocolitis — Duration: 3 mos

Due to

Due to

Other Conditions Gen. Arteriosclerosis, Senility — 2 yrs

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Feldman M. D.
Address 87 St Paul St Date signed 10/12/48

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The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G67572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. 32422

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Lunar 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 Lunar Aged Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Strauss

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Bernard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day hr.	min.
85				

9. Birthplace Hungray (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Morris Steiner
13. Birthplace Hungary

MOTHER
14. Maiden Name Mary
15. Birthplace Hungary

16 (a) Informant George Foth
(b) Address 3310 Walbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon Friendship
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place

OCT 12 1948 (b) (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11 1948, at 6:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1948, to 10-11 1948, and that I last saw h[illegible] alive on 10-8 1948.

23. Immediate cause of death	Duration
Severe Anemia	
Due to	
Due to	
Other Conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Cohen M. D.
Address Lunar Hosp Date signed 10-14-48

701

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67573 ✓ G67573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. County
(c) City or town Hickory (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #4 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME M. WILLIAM SMITH

3 (b) If veteran, name war World War 2

3 (c) Social Security Account No 244-34-1880

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married (Single)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14-1921

8. AGE: Years	Months	Days	If less than one day
27 (48)	0	27	hr. min

9. Birthplace Burke (Catawba) Co., N.C. (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business Motor Freight

FATHER
12. Name Jerry M. Smith
13. Birthplace North Carolina

MOTHER
14. Maiden Name Dennis (Vinna) Grace Shoe
15. Birthplace North Carolina

16 (a) Informant John O. Mitchell
(b) Address 1900 Eutaw Place 14

17 (a) 10/11/48 (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem. Mt. Stephens
Burial, cremation or removal Baltimore (Hickory) N.C.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw pl. Baltimore, Md.

19 [redacted] (Registered by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1948, at 12 25 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull & intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-10-48 at 11:55 P. M.
(b) Where did injury occur? Washington Blvd. at Patapsco River Bend Balto. County, Md.
(c) Did injury occur at home, on farm, in factory, in public place? Public While at work? No
(d) Means of injury Ped. struck by auto.

23. Signature Emil L. Kyle M.D.
Medical Examiner.
Date signed 10-11-48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6675

6675 6675 9 E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians, please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3501 Bancroft Road
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Bancroft Road. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3. (a) FULL NAME NATHAN ADLER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rachel Adler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 28, 1878.

8. AGE: Years 70 | Months 6 | Days 13/14 | If less than one day: hr. min.

9. Birthplace: Germany. (Town, county, and state)

10. Usual Occupation: Retired Executive
11. Industry or business

FATHER
12. Name: Selig Adler,
13. Birthplace: Germany.

MOTHER
14. Maiden Name: Rifka Selz,
15. Birthplace: Germany.

16. (a) Informant: Mr. Sidney Adler,
(b) Address: New York.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48. (month) (day) (year)
(c) Cemetery or crematory: Baltimore Hebrew
Location: Balto. Md.

18. (a) Funeral director: Harris Levine & Son
(b) Address: 1902 Eutaw Place.

Oct 12 1948 Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Oct. 11th. 1948 at 7.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Oct 11, 1948, and that I last saw h[illegible] alive on Oct 11, 1948

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to: Arteriosclerosis	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: Nil

Major findings of operation: Nil

of autopsy: Nil

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature: Sidney L. Levy

Address 2322 Eutaw Pl. Date signed (M) 10 (D) 12 (Y) 48

VS 150

6675?5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 6675?5

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 Colborne Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE T. DOCK

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-0264

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Mary E. Dock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1889

8. AGE: Years	Months	Days	If less than one day
59	9	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation machinist
11. Industry or business Crown Cork and Seal

FATHER
12. Name George W. Dock
13. Birthplace Westminster, Md.

MOTHER
14. Maiden Name Mary C. Casgro[illegible]
15. Birthplace Chambersburg, Pa.

16 (a) Informant Mary E. Dock
(b) Address 3716 Colborne Rd.

17 (a) Burial (b) Date thereof 10/14/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Washington Boulevard

18 (a) Funeral director Charles P. Towell
(b) Address 2427 Edmondson Ave.

OCT 12 1948 Edmonson Village, Md.
(Date rec'd by registrar) Registrar

V3 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1948, at 9:35 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary or secondary in causing death, fill in the following:
(a) Date of injury
(b) Where did injury occur?
(c) Did injury occur in home, on farm, in factory, public place?
(d) Means of injury
23. Signature
Date signed

667576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

667576
Registered No.

Physicians: please write the causes of death clearly and legibly. Spaces are especially important. Omission of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 N. Chester Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 N. Chester street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE STOLL

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: Michael Stoll

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1870

8. AGE: Years 78 | Months 7 | Days 27 25 | If less than one day: hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Fred Kahler
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine
15. Birthplace Germany

16 (a) Informant Mrs Walter F. Snellings
(b) Address 1815 N. Chester Street - 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/48 (month) (day) (year)
(c) Cemetery or crematory Moreland memorial
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY
(c) OCT 12 (Date rec'd by registrar) (d) Signature of registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 19 48, 4.25 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 19 47 to Oct 9 19 48.
and that I last saw her alive on Oct 9 19 48

Immediate cause of death: Acute Cardiac Failure — Duration: 18 hrs

Due to Chr. myocarditis

Due to Diabetes Mellitus

Diabetic Carbuncles.

Other Conditions Diabetic cataracts.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J S Harding M. D.
Address 3805 Belair Rd Date signed Oct 11/48

VS 150

G67577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67577 ✓ Registered No. 823a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5000 Denmore Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5000 Denmore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine E. Abell

3 (b) If veteran, name war: Spanish American

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1860

8. AGE: Years 87 | Months 11 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace St. Marys Co. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business R. N.

FATHER
12. Name George Abell
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Benson
15. Birthplace Md.

16 (a) Informant John W. Abell
(b) Address 5000 Denmore Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/13/48 (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Arlington, Va.

18 (a) Funeral director MARTIN FAHEY & SONS
(b) Address 1827 W. North Ave. - 17

19 (a) OCT 12 1948 (Date received by Registrar) **(b)** [signature] Registrar

V S 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1948 at 8A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Oct 1948.
and that I last saw her alive on Aug 15 1948.

Immediate cause of death Cerebral Thrombosis

Due to Arterio Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel A Gatins M. D.
Address 1211 Cathedral St Date signed Oct 11 1948

CORRECTION, WITH OVERLEAF INS. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

667578 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Haskin Court (If rural give location)
(e) Citizen of foreign country? Husband No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM EPHRIAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1894

8. AGE: Years 54 | Months 8 | Days 4 | If less than one day: hr. min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name George Ephrian
13. Birthplace Unknown

MOTHER
14. Maiden Name Ida Haines
15. Birthplace Alabama

16 (a) Informant Mrs. Eliza Ephrian
(b) Address Berkley, W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-48 (month) (day) (year)
(c) Cemetery or crematory Wildwood Cem.
Location West Virginia

18 (a) Funeral director MRS. FRANCES A. HEMSLEY
(b) Address 578 W. Biddle Street

OCT 12 1948 (Date rec'd by registrar) Remington Hillsborough

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1948, at 4:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of heart.
Acute edema of lungs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George C. Merrill M.D.
Medical Examiner.

Date signed 10-11-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

667579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 667579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. CARROLLTON AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERTA CHEW

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age . years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 57 | Months | Days | If less than one day: hr. min.

9. Birthplace Calvert Co., Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER — 12. Name John Gordy
13. Birthplace Md

MOTHER — 14. Maiden Name Louise Brown
15. Birthplace Md

16 (a) Informant Mr. John Gordy
(b) Address 1523 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mr. Frances A. Hemsley
(b) Address 57 E. 60. Biddle St.

19 (a) [redacted] (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1948, at 8:22 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1948 to Oct 4 1948, and that I last saw her alive on Oct. 4, 1948.

	Duration
Immediate cause of death: Hypertensive Cardio-Renal Disease	2 months
Due to: Hypertensive Cardio-Vascular Disease	6 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Homer W. Harris Jr. M. D.

Address 1824 W. Franklin St Date signed 10-9-48

Registrar

VS 190

PRINT WITH PLAIN, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67580 80

Registered No. 167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 18 Winters Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDITH M. BROWN CLARK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1917

8. AGE: Years	Months	Days	If less than one day
31	4	8	hr. min.

9. Birthplace Catonsville, Md. (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER
12. Name Dumas Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Hall
15. Birthplace Maryland

16 (a) Informant Mrs. Martha Brown
(b) Address 18 Winters Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-48 (month) (day)
(c) Cemetery or crematory Arbutus Mem Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 OCT 12 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1948 at 8.15 p.M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide X, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab wounds of chest and abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-9-48 at approx. 7.50 p. M.
(b) Where did injury occur? 18 Winters Lane
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Sharp Instrument

23. Signature [signature] M.D. Medical Examiner
Date signed October 11, 1948

VS 151

967581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

967581 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Mercy Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. #506 St. James Apts., 530 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LULU MAY HAGNER

22749

3 (b) If veteran, name war | 3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

20. DATE OF DEATH Oct. 11 1948 at 8:45AM

6 (b) Name of husband or wife Richard A. Hagner
6 (c) If alive, give age years

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1878

8. AGE: Years	Months	Days	If less than one day
70	8	11	hr. min.

IMMEDIATE CAUSE OF DEATH: Fracture of Skull
Fractured cervical Vertebral
Compound fracture Radius + Ulna (right)

Due to Mental depression

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

Other Conditions

(Include pregnancy within 3 months of death)

FATHER 12. Name Walter Foster
13. Birthplace England

MOTHER 14. Maiden Name Emma Collins
15. Birthplace Va.

16 (a) Informant: Mr. Donald F. Hagner
(b) Address Hopkins Apts., St. Paul & 31St.

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 11/48 8:30 AM.
(b) Where did injury occur? 5th. Floor, St. James Apts.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury: Jumped from fire escape

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 10/11/48

19 (a) (Date rec'd by registrar) (b) for Registrar

VS 151

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

G67582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G67582 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 757 W. Cross St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 757 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE DURHAM

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Logan Durham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1874

8. AGE: Years	Months	Days	If less than one day
74	8	1	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name - Southwood
FATHER 13. Birthplace Va.

MOTHER 14. Maiden Name Unknown
MOTHER 15 Birthplace "

16 (a) Informant Miss Della Durham
(b) Address 757 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1948, at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1947 to Oct 9, 1948.
and that I last saw her alive on Oct 9, 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 Day
Due to Hypertension	Years
Due to	
Other Conditions Cardiac Insufficiency	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify) (Place)
(e) Means of injury

23. Signature Abram Goldman M. D.
Address 206 S. Gilmor St. Date signed 10/13/48

Please write clearly with pen and ink. Use no abbreviations. If unknown, state so. Do not leave any question unanswered. Physicians: please write the causes of death clearly and legibly.

G67583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

Registered No. G67583

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32nd + Calvert St.
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 53
(e) Length of stay in Baltimore (yrs., mos., or days) 65yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2938 Beaumont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) NO
If yes, name country

3 (a) FULL NAME Miss Carrie E. Lober.

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NO

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: NONE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19 1882

8. AGE: Years 65 | Months 11 | Days 9 | If less than one day: hr. 21 min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Conrad Lober
13 Birthplace Maryland

MOTHER
14. Maiden Name Caroline Wagner
15 Birthplace Maryland

16 (a) Informant Mrs Carrie Sendrek
(b) Address 2867 Edmondson Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-13-48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE

18 (a) Funeral director JOHN T. STANSBURY
(b) Address 2700 EDMONDSON AVE.

19 (a) Date received OCT 12 1948 (Registrar) Director for Baltimore

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 1948 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1948 to Oct 10 1948, and that I last saw h c alive on Oct 10 1948.

Immediate cause of death General Peritonitis.

Duration 41 days

Due to Diverticulum of Stomach w duodenum ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 2nd + 29th 1948

Major findings of operation: Diverticulum of [illegible] General Peritonitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn P Grove M. D.
Address Union Memorial Hospital Date signed 10-10-48

VS 150

G67584

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G67584 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town) Middle River
(d) Street No. 1706 Wilson Point Rd. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN E. OWENS
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Wilhelmina Neunsinger
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 1, 1882
8. AGE: Years: 66 | Months: 2 | Days: 8 | If less than one day: hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Postal Service
FATHER 12. Name John T. Owens
13. Birthplace Md.
MOTHER 14. Maiden Name Katherine Brown
15. Birthplace Md.
16 (a) Informant Mrs. Wilhelmina Owens
(b) Address 1706 Wilson Pt. Rd., Ba. Co. 20 Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12, 1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Parkville, Maryland
18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.
OCT 13 1948 (Date rec'd by registrar)
(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1948 at 1:20 P.M
21. I certify that death occurred on the date above stated, that I attended deceased from 9-27 1948 to 10-9 1948 and that I last saw him alive on 10-9 1948
Immediate cause of death: Lobar Pneumonia — (a) Duration 11 days
Due to Anterior Myocardial Infarction due to Coronary Thrombosis — 14 days
Due to Arteriosclerotic Heart Disease — 6 yrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Edward A. Newell M. D.
Address 1213 Light St. Date signed 10-9-48

VS 152

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

G667585

BALTIMORE CITY HEALTH DEPARTMENT ✓ G667585 85
Registered No.

CERTIFICATE OF DEATH 74a

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 146 Irving st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patsy Ann Bennett

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13, 1933

8. AGE: Years	Months	Days	If less than one day
15	3	27	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation School-girl

11. Industry or business

FATHER
12. Name Robert M. Bennett
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Bertha V. Krauss
15. Birthplace Baltimore Md

16 (a) Informant Robert M. Bennett
(b) Address 146 Irving st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Laurel Md

18 (a) Funeral director Mrs. Mrs. Otho W. Linthicum
(b) Address 5311 Edmondson Ave

19 (a) Oct 12 1948 Wallington Williamson Md.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1948, at 9 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8 1948, to 10-10 1948, and that I last saw her alive on 10-10 1948.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Chronic Myelogenous Leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Gober M. D.
Address Sinai Hosp Date signed 10-10-48

VS 150

G67586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G67586 86 **Registered No.**

Physicians: please write the causes of death clearly and legibly. The age is especially important. Information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3420 Guilford Terrace
(c) Hospital or institution none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 Guilford Terrace (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anne Robertson Foster

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Edward F. Foster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1870

8. AGE: Years	Months	Days	If less than one day
78	7	27	hr. min.

9. Birthplace Chase City, Va. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Reps O. Osbourne
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Wallace Robertson
15. Birthplace Va.

16 (a) Informant Mrs. Angeline F. Williams
(b) Address RFD #2, Annapolis, Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount
Location North & Greenmount Aves., Balto.

18 (a) Funeral director John D. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) OCT 12 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/6 1948 to 10/11 1948, and that I last saw her alive on 10/4 1948.

Immediate cause of death Uremia — **Duration** 2 days

Due to Generalized arteriosclerosis. — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature George W. Mugler Jr. M.D.
Address 1114 St. Paul St. Date signed 10/12/48

Turnbull for Williams, Registrar

VS 150

X

G67587

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G67587 87 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2453 Maryland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2453 Maryland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marian Bell Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife F. Howard Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 26 - 1890

8. AGE: Years	Months	Days	If less than one day
58	5	15	hr. / min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Home duties
11. Industry or business

FATHER
12. Name John J. Bell
13. Birthplace Maryland

MOTHER
14. Maiden Name Jean S Speir
15 Birthplace Maryland

16 (a) Informant F. Howard Smith
(b) Address 2453 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director John A. Mitchell & Sons, Inc
(b) Address 1900 Eutaw Pl.

1948 OCT 12 (Date rec'd by registrar) Huntington Williams Registrar

VS 150 —

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1948 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Oct 11 1948, and that I last saw her alive on Oct 10 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to Hypertensive Cardio Vascular disease	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type / place)
(e) Means of injury

23. Signature W. H. Smith M. D.
Address 3429 Chestnut Ave. Date signed Oct 16. 48

X

HLH - 2667588 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G67588 88
Registered No.

CERTIFICATE OF DEATH 157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town Clark
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Guthrie Wetherington
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 11-15-47
8. AGE: Years 1 | Months | Days 26 | If less than one day hr. min.
9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Luke Wetherington
13. Birthplace N. C.

MOTHER
14. Maiden Name Mable Guthrie
15. Birthplace N. C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10 (month) 12 (day) 48 (year)
(c) Cemetery or crematory Swan-Harris
Location: New Bern, North Carolina

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto 31, Md.

19 (a) 10-12-48 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1948. to 10-11 1948.
and that I last saw him alive on 10-11 1948.

Immediate cause of death	Duration
a Nefrenia	
Due to enguited Ulcer disease	
Due to	
Other Conditions 0	

(Include pregnancy within 3 months of death)
Date of operation 10/11/48
Major findings of operation: Pul Atresia: dextroposition of
of autopsy: aorta

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature Albert Aiken
Address Johns Hopkins Hospital Baltimore
Date signed 10-12-48

VS 150

Physicians are especially important. Physicians: please write the causes of death clearly and legibly. The

G67589

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67589

Registered No. 157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor Ave
(c) Hospital or institution:
West Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs 36 min
(e) Length of stay in Baltimore (yrs., mos., or days) Never

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Glenburnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Oak Lane 8
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Cunningham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/10/48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace West Balto Gen. Hosp.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Edward Cunningham
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mildred Leona Wade
15 Birthplace Glen Bernie Md

16 (a) Informant: Mrs Mildred Cunningham
(b) Address 100 Oak Lane Glen Bernie

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13 1948 (month) (day) (year)

(c) Cemetery or crematory Glen Haven
Location Glen Bernie Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

(Date rec'd by registrar) Washington Millikin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11 1948 at 6:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1948 to 10/11 1948, and that I last saw her alive on 10/10 1948.

Immediate cause of death	Duration
Congenital heart lesion	
Due to Causes unknown	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. P. Young M.D.
Address West Balto Gen. Hosp Date signed 10/12

VS 150

G67590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67590 Registered No. 186a

The items of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Park Drive & 31st St.

(c) Hospital or institution: U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 yr 5 mo. 17 da.

(e) Length of stay in Baltimore (yrs., mos., or days): as "d"

2. USUAL RESIDENCE OF DECEASED:

(a) State: Ill. (b) County:

(c) City or town: Chicago (If outside city or town limits, write RURAL and give town)

(d) Street No.: 9229 Commercial Ave. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country:

3 (a) FULL NAME: HASSETT, Thomas Joseph

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	x

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 26, 1886

8. AGE: Years	Months	Days	If less than one day
61	11	13	hr. min.

9. Birthplace: Chicago, Ill (Town, county, and state)

10. Usual Occupation: Asst. steward

11. Industry or business:

FATHER — 12. Name: Patrick Hassett; 13. Birthplace: Ireland

MOTHER — 14. Maiden Name: Mary Hair; 15. Birthplace: Ireland

16 (a) Informant: Records

(b) Address: U. S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-12-48 (month) (day) (year)

(c) Cemetery or crematory St Peters

Location Lynnwood Ave

18 (a) Funeral director Earl B Johnston Inc

(b) Address 402-E-25th St

19 (a) [illegible] (b) [illegible] Registrar

(Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1948, at 5:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 22, 1947, to Oct. 9, 1948 and that I last saw him alive on Oct. 9, 1948.

Immediate cause of death	Duration
1. Carcinoma of left alveolar ridge with metastases	22 months
Due to 2. Fracture, left femur	9 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/6

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 9-29-48 at 10.30 AM

(c) Where did injury occur? U. S. Marine Hospital (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work? No

(e) Means of injury: Fainted and fell to floor

23. Signature: John L. Wilson M. D.

Address: Clinical Director Date signed 10-9-48

V S 150

G67591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Joppa (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 2-21-85

8. AGE: Years 63 | Months 7 | Days 18 | If less than one day: hr. min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Booze
15. Birthplace Md

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct-12-1948 (month) (day) (year)
(c) Cemetery or crematory: Pleasant Rest.
Location: Towson Balto Co Md

18 (a) Funeral director: Bryson & Ramp & W A Wright
(b) Address: 721 Eutaw St

19 (a) (Signature of registrar) Registrar
Oct 12 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 9 1948, at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16-1948 to 10-9-1948 and that I last saw her alive on 10-9-1948.

Immediate cause of death: Myocardial infarction — Duration

Due to: Coronary thrombosis

Due to: Syphilitic aortitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ~~Infarction, myocardium, coronary thrombosis~~

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town), (County), (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature: John Collins Harvey M D
Address: Johns Hopkins Hospital Date signed: 10-12-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 190

G67592

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G67592

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Pennsylvania Ave
(c) Hospital or institution: Provident Hospital 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Greene St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Woods

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe	Negro	W.

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov - 1887

8. AGE: Years	Months	Days	If less than one day
60	11		hr. min.

9. Birthplace Annapolis Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name William Harper
13. Birthplace Md.

MOTHER 14. Maiden Name Matilda
15. Birthplace Md.

16 (a) Informant Charles Woods
(b) Address 1804 Lauretta Ave

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10-13-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location G. A. Co.

18 (a) Funeral director Samuel W. Sullivan Jr
(b) Address 1011 N. Arlington Ave

19 (a) 10-13-1948 (b) Arlington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8- 1948, at 2:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 20-7- 1948, to 10-8-1948, and that I last saw h[illegible] alive on 10-8- 1948.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. E. Brady, M. D.
Address [illegible] Date signed 10-9-48

Important: Physicians, please write the causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure that all items are supplied. Use

G67593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G67593 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Park Drive & 31st Street

(c) Hospital or institution: U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 day

(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County: -

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 101 W. Monument Street (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country:

3 (a) FULL NAME: Capt IVERSON, GEORGE DUDLEY - Jr

3 (b) If veteran, name war	3 (c) Social Security Account No.
VA 1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	white	m

6 (b) Name of husband or wife: Alice Iverson (Mrs.)

6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Oct. 28, 1878

8. AGE: Years	Months	Days	If less than one day
69	11	13	14 hr. ... min.

9. Birthplace: Baltimore — Maryland (Town, county, and state)

10. Usual Occupation: none (Retired)

11. Industry or business: U. S. Army

FATHER — 12. Name: George D. Iverson; 13. Birthplace: Virginia

MOTHER — 14. Maiden Name: Alice Keeble; 15. Birthplace: Virginia

16 (a) Informant: Records

(b) Address: U. S. Marine Hospital

17 (a): Cremation (Burial, cremation, or removal) (b) Date thereof: 10 - 13 - 1948 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park

Location: Baltimore

18 (a) Funeral director: STEWART & MOWEN COMPANY

(b) Address: [illegible]

19 (a) [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11, 1948, at 9:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10, 1948 to Oct. 11, 1948, and that I last saw him alive on Oct. 11, 1948.

Immediate cause of death	Duration
1-Arteriosclerotic heart disease with coronary occlusion, partial	4 days
Due to	
Due to	
Other Conditions: 2-Carcinoma, urinary bladder	6 months

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: John L. Wilson

Address: Clinical Director Date signed: 10-11-48 M. D.

V S 150

93D

G67594

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

G67594
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 832 N. Bentalou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 832 N. Bentalou St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMILY WADKIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Harry Wadkin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 16, 1864

8. AGE: Years	Months	Days	If less than one day
84	8	24	hr. min.

9. Birthplace Sussex, England (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER	12. Name	Alfred Holloway
	13. Birthplace	England
MOTHER	14. Maiden Name	Elizabeth Nash
	15 Birthplace	England

16 (a) Informant Mrs. Gertrude M. Drexel, daughter
(b) Address 832 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1948 at 7:00P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1939 to Oct 10 1948 and that I last saw h alive on Oct 8 1948

Immediate cause of death Arteriosclerotic Cerebro-Thrombosis
Duration 5 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify in each place)
(e) Means of injury

23. Signature Albert Schochat M. D.
Address 232 Edmondson Ave Date signed 10/11/48

L. J. Schochat

VS 150

BC-48-21520 G62595

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a

Registered No. G62595

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item or information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
4
(d) Street No. 1304 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Linda Ann Liptrap

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1948

8. AGE: Years 0 | Months 0 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Leonard Liptrap
13. Birthplace Va.

MOTHER
14. Maiden Name Pearl Zittle
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Leonard Zittle
(b) Address 1304 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 12 (Date rec'd by registrar). Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1948 at 3 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1948 to Oct. 11 1948. and that I last saw h alive on Oct. 11 1948.

Immediate cause of death Exanition, dehydration — **Duration**
Due to diarrhea
Due to Cause undetermined
Other Conditions Bilateral pneumonia
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Bilateral pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Goldstein, M.D.
Address W84H Date signed 10/11/48

VS 150

G67596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52

G67596 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Omission or inaccuracy of information should be carefully avoided.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2302 W. Rogers Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 W. Rogers Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAGGIE ELLSWORTH ECCLESTON

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1864

8. AGE: Years	Months	Days	If less than one day
84	1	28 29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER: 12. Name Charles E. Eccleston
13. Birthplace Baltimore, Md.

MOTHER: 14. Maiden Name Margarita Grace
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Wm. A. Mihn
(b) Address 2302 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (Registrar)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1948, 10:30 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Feb. 1 1948 to Oct. 10 1948 and that I last saw her alive on Oct. 10 1948.

Immediate cause of death: Cancer Fall
Due to Coma, due to
Due to Hemorrhage of the brain
Due to
Other Conditions

Duration
8 yrs.
2 days
[illegible]

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herman R. Mantz M.D.
Address 2601 Maryland Ave Date signed Oct 11 48

Herman R. Mantz

G67597

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

36

Registered No. G67597

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 313 W. 28th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette Wilkins (Jeanette Farrell Wilkins)

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1948, at 10:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948 to Oct 10 1948 and that I last saw her alive on Oct 10 1948.

Immediate cause of death Poliomyelitis, Paralytic, Bulbospinal — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27, 1929

8. AGE: Years	Months	Days	If less than one day
19	7	13	hr. min.

9. Birthplace Baltimore, MD (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Farrell
13. Birthplace ?, Virginia

MOTHER
14. Maiden Name Helen? Edmonds
15. Birthplace Va

16 (a) Informant Deceased Patient
(b) Address

17 (a) Shepard (Burial, cremation, or removal) (b) Date thereof Oct 12-48 (month) (day) (year)
(c) Cemetery or crematory Lawrence Cemetery
Location Virginia

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

OCT 12 1948 (Date rec'd by) (b) [illegible] Registrar

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Doyle B. Arnold M. D.
Address Sydenham Hosp. Date signed 10-10-48

V S 190

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any errors or omissions in information should be carefully supplied. The

Dr. Morris Shamer
3300 W. North Ave.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 662598

82a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5109 Holder Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)
(d) Street No. 5109 Holder Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Homlet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	~~Negro~~ White	married

6 (b) Name of husband or wife Leola Homlet
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 24, 1882

8. AGE: Years	Months	Days	If less than one day
65	9	16	hr. min.

9. Birthplace San Francisco, Calif. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Fong Hom
13. Birthplace China

MOTHER
14. Maiden Name Soo
15. Birthplace China

16 (a) Informant Mrs. Leola Homlet
(b) Address 5109 Holder Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) (Date received by Registrar) OCT 12 1948 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10th 1948 at 2.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4, 1948 to Oct. 10, 1948 and that I last saw him alive on Oct. 9, 1948

Immediate cause of death	Duration
Cerebral thrombosis	7 days
Due to Hypertension	?
Due to	
Other Conditions Cerebral hemorrhage	2 mo

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Maurice L. Shamer M.D.
Address 3300 W. North Ave Date signed 10/11/48

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

G67593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G67599
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Latrobe Apts
(b) Street address Charles & Read Sts
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Latrobe Apts. & Charles & Read Sts (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Moale Nicholas

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2 1872

8. AGE: Years 76 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace Balto Co Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Wilson Cary Nicholas
13. Birthplace Balto Co. Md.

MOTHER 14. Maiden Name Augusta Moale
15. Birthplace Balto. City

16 (a) Informant C. M. Wedbee
(b) Address 1515 Bolton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1948 (month) (day) (year)
(c) Cemetery or crematory St Charles
Location Pikesville Md

18 (a) Funeral director Henry W. Jenkins & Sons Co
(b) Address 4965 York Rd

19 (a) Oct 12 1948 (Date received by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1948, at 4.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1948 to Oct 11 1948 and that I last saw him alive on Oct 10 1948

Immediate cause of death: Coronary Thrombosis — Duration 4 Days

Due to Arteriosclerosis, generalized

Due to

Other Conditions Paralytic Ileus cause undetermined
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Pearce M. D.
Address 2105 N Charles St Date signed Oct 11, 1948

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any omission or inaccuracy of information should be carefully supplied. The

VS 150

G67600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G67600 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 S. Chapel Gate Lane
(c) Hospital or institution: Ventnor Lodge
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 526 S. Chapel Gate Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRIETTA GRAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 20, 1872

8. AGE: Years 76 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Mass. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bailey
13. Birthplace unknown

MOTHER
14. Maiden Name
15 Birthplace unknown

16 (a) Informant Mrs. Elizabeth Henderson
(b) Address 50 Buttonwood Rd. Staten Island

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves

19 OCT 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1948, at 7.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 19 48 to October 12 19 48, and that I last saw her alive on October 11 19 48.

Immediate cause of death: Bronchopneumonia — Duration: 3 DAYS

Due to: senility

Due to:

Other Conditions: Arteriosclerosis, Hypertension, Chronic Myocarditis

Left complete hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin N. Borden M. D.
Address 2030 W. Fayette St Date signed 10/12/48

VS 189

107

Copy immediately. Physicians: please write the causes of death clearly and legibly. Use typewriter if convenient. Do not abbreviate. Be certain every item is correctly supplied. Use

667601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

667601 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 E. 24th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: CLARENCE W. WAGNER

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~ married, ~~widowed, divorced~~: Married

6 (b) Name of husband or wife: Peggy Wagner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 14, 1895

8. AGE: Years 52 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Painter

11. Industry or business: Lewis Brothers

FATHER
12. Name: Dr. Frank E. Wagner
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Alice C. Ward
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Peggy Wagner
(b) Address: 311 E. 24th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-48 (month) (day) (year)
(c) Cemetery or crematory: U. S. National
Location: Baltimore, Maryland

18 (a) Funeral director: WILLIAM COOK, INC.
(b) Address: 1217 St. Paul Street

19 (a) OCT 13 1948 (Date rec'd by registrar) (b) Filed [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1948 at 5:05 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of skull with intracranial hemorrhage

Due to

Other Conditions: Multiple fractures of ribs and clavicle
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-9-48 at 12:30 P. M.
(b) Where did injury occur? 3192 Brighton Street
(c) Did injury occur at home, on farm, industrial place, in public place? Roof of home While at work? Yes
(d) Means of injury: Fell from roof while painting

23. Signature [signature] M.D. Medical Examiner.
Date signed 10-12-48

VS 151

67602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121

Registered No. G67602

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Gregory Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gail Linda Bergman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 7, 1946

8. AGE: Years	Months	Days	If less than one day: hr.	min.
2	1	5		

9. Birthplace Baltimore, Maryland (Town, county and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name GILBERT D. BERGMAN
13. Birthplace MISS.

MOTHER
14. Maiden Name EDNA A. McCULLEY
15. Birthplace MARYLAND

16 (a) Informant GILBERT D. BERGMAN
(b) Address 1104 GREGORY AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location BALTIMORE, Md.

18 (a) Funeral director WILLIAM COOK, INC
(b) Address 1217 ST. PAUL ST.

19 OCT 13 1948 (Date received by Registrar) (Signature) Courtenay Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1948, at 1 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1948 to Oct. 12 1948, and that I last saw h er alive on Oct. 12, 1948

Immediate cause of death: Generalized peritonitis following gangrenous appendicitis with perforation — Duration: 6 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct. 12, 1948

Major findings of operation: Ruptured gangrenous appendix and ~~abscess~~ generalized peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter B. Langer, M.D.
Address Bon Secours Hospital Date signed 10/12/48

VS 150

67603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G67603

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St
(c) Hospital or institution Good Samaritan Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 N Rusgath St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eula Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 18-1897

8. AGE: Years 50 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Birmingham ala (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Jesse Robinson
13. Birthplace ala

MOTHER 14. Maiden Name Rena Robinson
15. Birthplace ala

16 (a) Informant Dr Mc Elroy
(b) Address 1402 E Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co

18 (a) Funeral director Layne Sanders
(b) Address 1412 E Preston St

1948 OCT 13 1948 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1948 at 5 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1948 to Oct 9 1948.
and that I last saw her alive on Oct 9 1948

	Duration
Immediate cause of death Myocarditis	Unknown
Due to Uraemia	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen E Forbes M.D.
Address 501 Edmondson Date signed 10/13/48

V S 150

Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. Age is especially important.

Medical Examiners Case

67604 JL - 123056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 67603

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2619 Cecil Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Melville

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 7, 1860

8. AGE: Years 88 | Months 6 | Days 1 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Sam Clark

13. Birthplace Md.

MOTHER 14. Maiden Name Ann

15. Birthplace Md.

CERTIFICATION APPROVED BY
M.D.
CHIEF OR ASST. MEDICAL EXAMINER

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Road

18 (a) Funeral director Austin C. Donovan

(b) Address 3638 Poland Ave

19 OCT 13 1948 (Date rec'd by registrar) (b) Huntington-Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1948 at 3PM M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 17 1948 to Oct. 11 1948. and that I last saw her alive on Oct. 11 1948.

Immediate cause of death: Pulmonary Edema — Duration 4 hrs

Due to: arterio Sclerotic Heart disease. years

Due to:

Other Conditions: Fractured neck of B/F femur. — 27 days

(Include pregnancy within 3 months of death)

Date of operation: 9-26-48

Major findings of operation: 9-29-48

of autopsy: Pulmonary edema

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 9-15-48 at M

(c) Where did injury occur? Baltimore (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no

(e) Means of injury fell. Slipped and fell to floor

23. Signature J. E. Geoghegan M. D.

Address 4940 Eastern Ave Date signed 10-17-48

To be approved by Medical Examiner

VS 150

Please write the causes of death clearly and legibly.

G67605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G67605 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5920 Bell Grove Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOTTIE MAE UTLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 5, 1901

8. AGE: Years 47 | Months | Days 6 | If less than one day hr. min.

9. Birthplace Sardis, Georgia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Ben Coglin
13. Birthplace Georgia

MOTHER
14. Maiden Name Sallie Ellison
15. Birthplace Georgia

16 (a) Informant Bennie Coglin
(b) Address 1726 McKean Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location Balto Co

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna Ave

OCT 13 1948 (Date received by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1948 at 9.50 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to Compound Fracture of Pelvis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-11-48 at approx. 7.55 p. M.
(b) Where did injury occur? Hoffman St. & Bell Grove Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury Struck by auto

23. Signature [signature] M.D.
Medical Examiner
Date signed October 12, 1948

667606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

667606 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1526 Baker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 Baker Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HANNAH SPENCER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Benjamin
6 (c) If alive, give age 189 years

7. Birth date of deceased (mo., day, yr) July 8, (1871)

8. AGE: Years	Months	Days	If less than one day
57	3	3	hr. min.

9. Birthplace Pikesville, Maryland. (Town, county, and State)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name George Houston
13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden Name Laura Sullivan
15. Birthplace Maryland.

16 (a) Informant Mrs. Anita Diggs
(b) Address 834 E. Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 OCT 13 1948 (Date rec'd by registrar) (c) Huntington Williams, M.D. Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11- 1948, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1948 to 10-11- 1948 and that I last saw h[illegible] alive on 10-11- 1948.

Immediate cause of death	Duration
Gastric Carcinoma	
Due to Chron Gastritis	
Due to	
Other Conditions	

(Include pregnancy within three months of death)

Date of operation Don't Know
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm R Boykin M.D.
Address 1133 Monroe Date signed 10/12/48

X

G67607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G67607

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2511 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SILAS BERRY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Eliza Berry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1871

8. AGE: Years	Months	Days	If less than one day
77	2	24	hr. min.

9. Birthplace Gloucester Co. Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Mattie Brown
(b) Address 521 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimote, Maryland.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) OCT 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10th 1948, at 2 45 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from 4/12 1948 to 10/10 1948, and that I last saw h alive on 10/10 1948.

Immediate cause of death Cardio Vascular Renal Disease
Due to arterio sclerosis

Duration: 2 yrs

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Jackson M. D.
Address 600 N. Arlington Ave. Date signed 10-12-48

VS 193

67608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 66[illegible]13

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1417 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM THOMAS CARTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Florence Hughes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 30, 1876

8. AGE: Years	Months	Days	If less than one day
72	4	12	hr. min.

9. Birthplace Lynchburg, Va.
(Town, county, and state)
10. Usual Occupation Caterer
11. Industry or business

FATHER
12. Name William H. Carter
13. Birthplace Lynchburg, Va.

MOTHER
14. Maiden Name Courtney Carter
15. Birthplace Lynchburg, Va.

16 (a) Informant Mrs. Florence Hughes Carter
(b) Address 1417 Madison Ave.

17 (a) Burial (b) Date thereof 10/16/'48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) OCT 13 1948 (b) [signature]
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1948 at 7:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1948 to 10-12 1948
and that I last saw h[illegible] alive on 10-11 1948

Immediate cause of death: Acute Cardiac Dilatation
Due to: Coronary Thrombosis Angina ?
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2033 Eutaw Place Date signed 10/14/48

VS 150

667609 D.C. 12-2888

2988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

667609

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution:
Provident Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 3day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 528 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maynard Marie Blythe

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/9/48

8. AGE: Years	Months	Days	If less than one day
		3day	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Woman Infant
11. Industry or business

FATHER
12. Name Theodore Blythe
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret Wilson
15. Birthplace Baltimore Md

16 (a) Informant Mrs Margaret Blythe
(b) Address 528 N Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. E. Kelson
(b) Address 1300 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Interring Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12/48, at 8:37 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1948, to 10/12 1948
and that I last saw h alive on 10/12/48

Immediate cause of death
Parchet Hemorrhage?
Prematurity

Due to

Due to Toxemia of Pregnancy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 10/12/48 at 5:27 P.M.
(c) Where did injury occur? Balto (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Louis Jones M.D.
Address 1100 Druid Hill Ave Date signed 10/13/48

OCT 13 1948
(Date rec'd by registrar)

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67610

108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 926 Shields Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Hooper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Jacob Hooper (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 5, 1903

8. AGE: Years 45 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Machine Operator

11. Industry or business

FATHER 12. Name Solomon Tulgham

13. Birthplace Va.

MOTHER 14. Maiden Name Mary Jd. James

15 Birthplace Va.

16 (a) Informant Helen Hooper

(b) Address 926 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Octoba 13, 1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial.

Location

18 (a) Funeral director Wm Kater Williams

(b) Address 922 W. Lanvale St.

19 (a) OCT 13 1948 (Date rec'd by registrar) (b) Cunningham for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 1948, at 3:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 1948 to 10/8 1948, and that I last saw h[illegible] alive on 10/7 1948.

Immediate cause of death

(a) Lobar Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: (a) 3 wks

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Wm Cannon M. D.

Address 753 George St. Date signed 10/11/48

VS 150

667611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667611

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: WILLIAM WASHINGTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April, 1898

8. AGE: Years	Months	Days	If less than one day
50	6		hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Washington
13. Birthplace Virginia

MOTHER
14. Maiden Name Ida Johnson
15. Birthplace Baltimore, Md.

16 (a) Informant Annie Wells
(b) Address 949 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Balto. Md.

18 (a) Funeral director Katie R. Williams
(b) Address 3229 W. Lehmoody St

19 (a) OCT 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1948 at 9:48AM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner
Date signed Oct. 11, 1948

VS 151

G67612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124R

G67612 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2633 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2633 E. Madison St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK J. RUZICKA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mary Charvat Ruzicka

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 15. 1876

8. AGE: Years 71 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation retired police

11. Industry or business

FATHER 12. Name Frank J. Ruzicka
13. Birthplace Czechoslovakia

MOTHER 14. Maiden Name Anna Bolek
15 Birthplace Czechoslovakia

16 (a) Informant Mrs. Mary Charvat Ruzicka
(b) Address 2633 E. Madison Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 10 13 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1948 at 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1948 to Oct 10 1948, and that I last saw him alive on Oct 10 1948

Immediate cause of death (a) Hypostatic Pneumonia — Duration Oct 7 48
Due to Contusion of Liver — April 48
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bonner M. D.
Address 8014 Kenwood Ave Date signed 10/11/48

VS 150

G67613

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67613 ✓ Registered No. 121a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2708 Erdman Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4552 Sheldon Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Dvorak

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or ~~wife~~ Frank Dvorak
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Aug. 30, 1874
8. AGE: Years 74 | Months 1 | Days 13 | If less than one day hr. min.
9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Vaclav Sappe
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mrs. Clara D. Kandlik - dght.
(b) Address 2708 Erdman Avenue

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/15/48 (month) (day) (year)
(c) ~~Cemetery~~ or crematory Greenmount
Location North Ave. & Oliver St.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) Date received by registrar OCT 18 1948 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1948, at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1948 to October 12 1948
and that I last saw h[illegible] alive on October 11 1948.

Immediate cause of death
Hypertension, cardiac renal
Cause A Uremia — Duration 10 days

Due to
Cause B
Due to
Cause C
Other Conditions Pneumonia — 6 days
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Alex L. Sokorsky M. D.
Address 2939 N. Fulton Ave. Date signed 10/14/48

G67614

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

✓ G67614
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Rest Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Wilmot Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Denmead

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John Denmead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1870

8. AGE: Years	Months	Days	If less than one day
78	3	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Samuel Freede
13. Birthplace Germany

MOTHER
14. Maiden Name Walberta ?
15. Birthplace Germany

16 (a) Informant Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

OCT 18 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1948, at 3:55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1948, to Oct 12 1948, and that I last saw her alive on Oct 11 1948.

Immediate cause of death: Chronic myocarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Patterson
Address 2324 Reisterstown Rd Date signed 10/12/48 (M. D.)

G67615

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 5

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1449 Patapsco St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1449 Patapsco St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUGENE J. HENNESSY

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1894

8. AGE: Years	Months	Days	If less than one day
53	10	1	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name John J. Hennessy
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary R. Newman
15. Birthplace Baltimore

16 (a) Informant Miss Rebecca A. Hennessy
(b) Address 1449 Patapsco St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Brooklyn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 13 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1948, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1948 to Oct 11 1948 and that I last saw h[illegible] alive on Oct 11 1948.

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to Hypertension	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 1225 Allendale Date signed 10/12/48

VS 130

G67616 ✓ G67616

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2534 McCulloh Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILA VICTORIA HICKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 22, 1889

8. AGE: Years	Months	Days	If less than one day
59	7	20	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Morris
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Morris
15. Birthplace Va.

16 (a) Informant Clarence Hicks
(b) Address 2534 McCulloh Street

17 (a) Burial (b) Date thereof 10/13/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Cedar Hill, Maryland

18 (a) Funeral director Charles [illegible], Inc.
(b) Address 302 Madison Avenue

(a) OCT 12 1948 (b) Huntington Hollins Mortuary
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1948 to Oct 12 1948 and that I last saw her alive on Oct 11 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 mos.
Due to Cardio Vascular Disease	1 yr.
Due to Hypostatic Pneumonia	1 day.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Tracy M. D.
Address 1928 Pennsylvania Ave Date signed 10/12/48

X

VS 150

66761?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. 66761?

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Argyle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROLAND WILKERSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	married

6 (b) Name of husband or wife Edna Mary Wilkerson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1948

8. AGE: Years	Months	Days	If less than one day: hr.	min.
48	-	29		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business McCormick Coal Co.

FATHER
12. Name Perry Wilkerson
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Sims
15. Birthplace Maryland

16 (a) Informant Edna Mary Wilkerson
(b) Address 1520 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park
Location Arbutus, Maryland
18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.
19 (a) (Registrar) Huntington Williams, M.D. Registrar
(b)

OCT 13 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1948, at 8 p.M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Illuminating Gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-11-48 at approx. 5 p. M.
(b) Where did injury occur? 1520 Argyle Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Open on stove, on but unlit
23. Signature Earl L. Kyle M.D. Medical Examiner
Date signed October 12, 1948

ES-G67618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G67618 Registered No.

Please write and causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Florence L. Rous - FLORENCE L. ROUS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 13, 1878

8. AGE: Years	Months	Days	If less than one day
70	9	29	hr. min.

9. Birthplace Md. Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name James A.
13. Birthplace Md.

MOTHER 14. Maiden Name Rebecca Brandt
15. Birthplace Md.

16 (a) Informant RECORDS- BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT 14/48 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location BALTIMORE MARYLAND

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 EUTAW PLACE...17

OCT 13 1948 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12 1948, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 1933, to 10-12 1948, and that I last saw her alive on 10-12 1948.

Immediate cause of death
Unknown
Due to Bronchopneumonia? 2 wks ?
Due to ACVD
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. T. Nelson M. D.
Address Date signed 10-12-48

G67619

G67619

BC-KE-29241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address _____
(c) Hospital or institution: Maryland Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 min
(e) Length of stay in Baltimore (yrs., mos., or days) 8 min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Chesley Ave, #6
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3 (a) FULL NAME Baby Boy Preisinger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 12 Oct 48

8. AGE: Years	Months	Days	If less than one day
0	0	0	0 hr. 8 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Newborn.

11. Industry or business _____

FATHER
12. Name Robert H Preisinger
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Thelma R Hatton.
15. Birthplace Balto., Md.

16 (a) Informant mother.
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14th 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E North Ave Ext

18 (a) Funeral director Lee G. Cook
(b) Address 1701-03 N Patterson Park Ave

19 (a) [illegible] registrar (b) Washington Heights Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Oct 1948, at 10 06 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Oct 1948 to 12 Oct 1948, and that I last saw him alive on 12 Oct 1948.

Immediate cause of death	Duration
Congenital Atelectasis.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: _____

of autopsy: Congenital Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? _____
(e) Means of injury _____

23. Signature Albert F. Schoenthaler M. D.
Address Maryland Gen Hosp Date signed 13 Oct 48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

VS 180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667620 94a 667620

Registered No.

667620

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 924 Wilmont Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 924 Wilmont Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRIET ROLFE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife William J. Rolfe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1876

8. AGE: Years	Months	Days	If less than one day
72	9	10	hr. min.

9. Birthplace Gloverville, New York
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

FATHER
12. Name John F. Burns
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. George R. Rolfe
(b) Address 924 Wilmont Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16,48 (month) (day) (year)
(c) Cemetery or crematory Riverside Cemetery
Location Rochester, N. Y.

18 (a) Funeral director Elmer W. Conklin
(b) Address 924 E. Eager St.

OCT 13 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1948, at 6.01 P.M.

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Rogers M.D.
Medical Examiner.
Date signed October 13, 1948

VS 151

G67621

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G67621 Registered No. 1176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 3
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 829 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE E. PENN
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Harry Penn
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Sept 9 1881
8. AGE: Years 67 | Months | Days 3 | If less than one day hr. min.
9. Birthplace Balto Co. Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Daniel B Hilter
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth A Burke
15. Birthplace Maryland

16 (a) Informant Daniel B Hilter (brother)
(b) Address 3543 Chestnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15-1948 (month) (day) (year)
(c) Cemetery or crematory Bethlehem
Location Stiltz Pennsylvania
18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
Huntington Baltimore, Md.

OCT 13 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1948, at 9:34 M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/8 1948 to 10/12 1948, and that I last saw her alive on 10/12 1948.

Immediate cause of death Pulmonary Embolism — Duration

Due to Perforated duodenal ulcer

Due to Generalized peritonitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/11 1948

Major findings of operation: Perforated duodenal ulcer, peritonitis.

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred Hawkins Jr. M.D.
Address Franklin Square Hosp. Date signed 10/13/48

VS 150

667622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

667622 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 S. Newkirk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Deuel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-8-07

8. AGE: Years	Months	Days	If less than one day: hr.	min.
41	6	5		

9. Birthplace New York (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Dan Deuel
13. Birthplace New York

MOTHER
14. Maiden Name Louise Vanderpool
15. Birthplace Florida

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15/48 (month) (day) (year)
(c) Cemetery or crematory St Annis
Location Annapolis Md

18 (a) Funeral director C. H. Hopkins & Son
(b) Address Annapolis Maryland

19 (a) Date received by registrar OCT 18 1948 (b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1948 at 8 26 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1948, to 10/13 1948, and that I last saw him alive on 10/13 1948.

Immediate cause of death	Duration
Craniopharyngeomathid Ventricle	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Oct 12, 48
Major findings of operation: large tumor Third ventricle (1)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature George G. Culbreth
Address Johns Hopkins Hospital Date signed Oct 13, 48 M D

X

667623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

667623 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: U.S. Marine Hospital 26th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3215 Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander Luckton

3 (b) If veteran, name war, World War #1

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Batrin Luckton

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) August 29, 1895

8. AGE: Years 53 | Months 1 | Days 13/14 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business Retired

FATHER 12. Name Prokief Luckton

13. Birthplace Russia

MOTHER 14. Maiden Name Anna

15. Birthplace Russia

16 (a) Informant Records

(b) Address U. S. Marine Hospital.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-48 (month) (day) (year)

(c) Cemetery or crematory United States Nat.

Location Baltimore, Maryland

18 (a) Funeral director WILLIAM COOK, INC.

(b) Address 1217 St. Paul Street

19 (a) OCT 14 1948 (Date rec'd by registrar) (b) Emerson Wilkinson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1948 at 12 00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Schmidt M.D. Medical Examiner.

Date signed 10/12/48

VS 151

X

G67624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67624

15 E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Conn. County
(c) City or town Shelton (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 John St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis Cantini

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-25-43

8. AGE: Years 4 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Francis Cantini

13. Birthplace Texas

MOTHER 14. Maiden Name Mary Delvastro

15. Birthplace Conn.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 14, 1948 (month) (day) (year)

(c) Cemetery or crematory Shelton

Location Shelton, Conn.

18 (a) Funeral director Ulbright Funeral Home

(b) Address 200 Orleans St

19 OCT 14 1948 (Date rec'd by registrar) Huntington Williams M.D. REGISTRAR

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1948 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1948 to Oct 13 1948 and that I last saw h[illegible] alive on Oct 13 1948.

Immediate cause of death	Duration
Shock	
Due to Post operative	
Due to Congenital Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct 13, 1948

Major findings of operation: Patent Ductus Arteriosus

Date of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature D.D. Cooley M.D.

Address St. J.H. Hospital Date signed Oct 13 '48

VS 150

67625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. G67625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Cherry

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife James W. H. Cherry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 5-1887

8. AGE: Years 61 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Kate Patrick
13. Birthplace Ohio

MOTHER
14. Maiden Name Nina Drummond
15. Birthplace Fla.

16 (a) Informant James W. H. Cherry
(b) Address 1605 Fulton Ave

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 10-15-48 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Balto Co.

18 (a) Funeral director Samuel W. Culbreth
(b) Address 1211 N. Arlington Ave

19 (Date received by registrar) OCT 14 1948 Arlington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1948, at 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/26 1948 to 10/12 1948.
and that I last saw h[illegible] alive on 10/11 1948

Immediate cause of death: hypertensive cardio-renal disease
Due to (cardiac failure)
Duration: sev. yrs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify one)
(e) Means of injury

23. Signature RAYNER BROWNE, M.D. M. D.
Address 1500 EAST MADISON ST. Date signed 10-12-48
BALTIMORE, MD.

VS 159

667626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 667626

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4323 Glenmore Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 d
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4323 Glenmore Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES E. HAINES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joanna Fossett

6 (c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.) 5/25/1866

8. AGE: Years 82 | Months 4 | Days 16 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name David H. Haines
13. Birthplace Md.

MOTHER
14. Maiden Name Mary C. Dehl
15 Birthplace Maryland

16 (a) Informant: J. Harold Wells
(b) Address 4323 Glenmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 (month) 14 (day) 48 (year)
(c) Cemetery or crematory Taylorsville
Location Taylorsville, Maryland

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto. 31

19 OCT 14 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1948 at 7.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1948 to Oct 1948 and that I last saw h[illegible] alive on Oct. 11 1948.

Immediate cause of death Heart Failure — Duration 1 Day

Due to Myocardia Insufficiency — 2 mos

Due to Arteriosclerotic Cardio Vascular disease — 5 years

Other Conditions ~~Etc~~ Incontinence, Senile — 1 Day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature [illegible]
Address 403 S. Wolfe St. Date signed Oct 13 1948 M.D.

VS 159

667627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 2 C

Registered No. 667627

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2918 Erdman Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Charles Leroy Haslup.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-28-5523

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mary Ellen Haslup
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr) Dec. 22, 1873

8. AGE: Years	Months	Days	If less than one day
74	9	20	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Hardware salesman
11. Industry or business

FATHER 12. Name Leroy F. Haslup.
13. Birthplace Maryland

MOTHER 14. Maiden Name Sarah Margaret Washington
15. Birthplace England

16 (a) Informant Mrs. Charles LeRoy Haslup (son)
(b) Address 2830 Mayfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct/13/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave. Cor. Huntington Ave. Baltimore, Md.

1948 OCT 14 (b) (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1948 at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1948 to Oct 12 1948 and that I last saw him alive on Oct 12 1948.

Immediate cause of death Cerebral thrombosis — Duration 2 days
Due to Arteriosclerosis, generalized — Duration years
Due to
Other Conditions old myocardial infarction
(Include pregnancy within 3 months of death)
Date of operation Oct 12, 1948
Major findings of operation: [redacted]
of autopsy: As above - Head not permitted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. F. Cox, Jr. M.D.
Address Union Memorial Hosp. Date signed 10-12-48

VS 150

G67628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G67628

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2612 Hurley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Grossman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1883

8. AGE: Years 65 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Louis Grossman
(b) Address 2612 Hurley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-48 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Friendship

18 (a) Funeral director Jack Lewis
(b) Address 206 Eutaw Place

19 (a) OCT 14 1948 (Date rec'd by registrar) (b) Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13 1948, at 3:18 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10/3 1948 to 10/13 1948, and that I last saw her alive on 10/13 1948

Immediate cause of death Uremia — Duration

Due to Chronic Pyelonephritis

Due to

Other Conditions Hypertension Cardiovascular Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard Copper M.D.
Address Sinai Hospital Date signed 10/13/48

VS 150

Physicians: please write the causes of death clearly and legibly.

G67629

BALTIMORE CITY HEALTH DEPARTMENT

MA/AMcd CERTIFICATE OF DEATH 94a

Registered No. G67629

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2807 Waldorf ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Waldorf ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Julius Mulamud

3 (b) If veteran, name war ~~served~~ U.S. Army Ret. during prev
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed or divorced~~
Male	White	Married

6 (b) Name of husband or wife Mrs. Bessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1865

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Russia - Poland
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Cleaning & repairing

FATHER
12. Name Isar Mulamud
13. Birthplace Poland

MOTHER
14. Maiden Name Golding Mulamud
15. Birthplace Poland

16 (a) Informant Bessie Mulamud
(b) Address 2807 Waldorf ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 7100 Eastern Place

19 (a) OCT 14 1948 (Date rec'd by registrar) (b) Funeral Home, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1948, at 9:36 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1948, to Oct 13 1948, and that I last saw him alive on Oct 13 1948.

Immediate cause of death	Duration
Complete Coronary occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Nadler M.D.
Address 2306 Eutaw Pl Date signed 10-13-48

VS 150

Physicians: please write the causes of death clearly and legibly. Omit terminal conditions; state only important conditions resulting in death. Do not report symptoms. Indefinite or obsolete terms should not be used. Information supplied.

67630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registrar's No. 67660

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Violet Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARNEY Gold

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 63 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Tailor

11. Industry or business

FATHER
12. Name: Louis
13. Birthplace: Russia

MOTHER
14. Maiden Name: Reba
15. Birthplace: Russia

16 (a) Informant: Joseph Gold
(b) Address: 1925 No Druid Land St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-48 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Young Men's
Location: Woodlawn Mill Road

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 200 Eutaw Place

19 (a) OCT 14 1948 (Date rec'd by registrar) (b) Huntington Mills, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1948 at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1948 to 10/12 1948 and that I last saw him alive on 10/12 1948. 11:35 AM

Immediate cause of death: Congestive Heart Failure — Duration

Due to: Arteriosclerotic Heart Disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide: No Evidence
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Bernard Kepper M.D.
Address: Sinai Hospital Date signed 10/12/48

VS 150

Please write plainly. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

667631

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667631
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 940 Whitelock St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-1
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 940 Whitelock St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Latvia (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Ruben Sacks
13. Birthplace Latvia

MOTHER 14. Maiden Name Bluma
15. Birthplace Latvia

16 (a) Informant Hyman Smith
(b) Address 940 Whitelock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place

19 (a) Huntington Williams Mortuary
(Date rec'd by local reg.) OCT 14 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 13 - 1948, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January, 1945 to 10/13, 1948.
and that I last saw her alive on 10/3/48

Immediate cause of death Myocardial Failure
Myocarditis

Duration 7 yrs.

Due to Senile Degeneration, arteriosclerosis

Due to

Other Conditions Senile Dementia

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Adelsund M.D.
Address 1 E Franklin St Date signed 10/14/48

VS 150

676632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43B

Registered No. 676632

1. PLACE OF DEATH: Levindale Home
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 48

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHILIP MENDEL NEWHOUSE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 86 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Jacob Newhouse
13. Birthplace Russia

MOTHER
14. Maiden Name Ettie ?
15. Birthplace Russia

16 (a) Informant Mrs Elsie Goldberg
(b) Address 3216 Fredwick ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14/48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rodale Cemetery
Location Rodale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W North ave

19 (a) [illegible] Washington Millicent Mc (Dep. Sec.'s Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1948 at 11 05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1948 to October 13 1948, and that I last saw him alive on October 13 1948.

Immediate cause of death: Cerebral thrombosis — Duration

Due to: Cerebral arteriosclerosis

Due to:

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Jerome J. Blumberg M. D.
Address Levindale Home Date signed 10/13/48

VS 150

X

G67633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

Registered No. G67633

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1825 EDMONDSON AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RUSSELL JAMES HARPER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1898

8. AGE: Years	Months	Days	If less than one day
50	4		hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Harper.
13. Birthplace St. Mary Co. Md.

MOTHER
14. Maiden Name Mary Handy
15. Birthplace Baltimore, Md.

16 (a) Informant Ernest Harper.
(b) Address 1825 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Katy K. Williams
(b) Address 322 N. Schroeder St.

19 (a) OCT 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1948, at 6:40AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9, 1948, to Oct. 12, 1948, and that I last saw him alive on Oct. 12, 1948.

Immediate cause of death HYPERTENSIVE CARDIO-RENAL DISEASE — Duration

Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas W. Harris M. D.
Address 1924 W. FRANKLIN ST. Date signed 10-12-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any false statement or information should be carefully supplied. The

VS 180

67634 ✓ 67634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT ASHBY

3 (b) If veteran, name war World War 2

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1912

8. AGE: Years	Months	Days	If less than one day
36 35	7	27	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. Ashby
13. Birthplace 1202 Edmondson Ave.

MOTHER
14. Maiden Name Elizabeth Franklin
15. Birthplace Va.

16 (a) Informant: Wm. Ashby
(b) Address 1202 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-48 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location 5500 Frederick Ave

18 (a) Funeral director Joseph S. Loeb Jr.
(b) Address 1304 N. Central Ave

19 (a) OCT 14 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1948 at 2:35PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab wound of right Femoral artery

Due to
Fracture of neck.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 9/48 at approx. 2:30 P.M.
(b) Where did injury occur? Front of 903 Madison Ave. on the Sidewalk
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Sharp instrument

23. Signature Thos. S. Kenedy M.D. Medical Examiner.
Date signed 10/13/48

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667635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667635 Registered No.

1220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1441 Betsy Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Monti, MARGARET A

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife Anthimio Monti
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1870

8. AGE:

Years	Months	Days	If less than one day
78	3	21/29	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Vito [redacted] Pelligrino
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine Scarpio
15. Birthplace Italy

16 (a) Informant Mrs L. Marco
(b) Address 3528 Carbon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Krause Funeral Home
(b) Address 216 E. Chase St

19 (a) [illegible] (b) Huntington Hollidaysburg, Pa. Registrar

OCT 14 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1948 at 9:45 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 5 1948 to Oct 11 1948, and that I last saw he alive on Oct 11 1948

Duration

Immediate cause of death Pulmonary embolism
Due to Pelvic thrombophlebitis
Due to
Other Conditions Uremia, Myocardial damage, Peritonitis (Including pregnancy within 3 months of death)

Date of operation 10-6-48
Major findings of operation: Strangulated abdominal hernia, gangrene appendix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph B. Schrenk M.D.
Address Franklin Sq Hosp Date signed 10-11-48

100

667636

667636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2005 E. FAYETTE ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 74 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2005 E. FAYETTE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA FABISZAK

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED.

6 (b) Name of husband or wife JOHN FABISZAK.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min
98	11			

9. Birthplace Poland.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE
11. Industry or business OWN HOME

FATHER
12. Name FRANK, UNKNOWN
13. Birthplace POLAND.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace POLAND

16 (a) Informant FLORENCE UTTENREITHER
(b) Address 2005 E. FAYETTE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-15-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Dorman Hill Rd.

18 (a) Funeral director F. W. Ogonowski
(b) Address 1930 Eastern Ave.

OCT 14 1948 (Date received by registrar) Huntington Williams, M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 12 1948 at 7 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 8, 1948 to Oct. 11 1948 and that I last saw h[illegible] alive on Oct. 11, 1948

Immediate cause of death	Duration
Acute Myocardial Insufficiency	one day
Due to Chr. Myocarditis	?
Due to Acute Atherosclerosis	
Due to	
Other Condition Cataract of both eyes	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 10/14/48

G676537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G676537

Registered No. 12a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 12-9 William St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 12-9 William St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John C. Kavanaugh

3 (b) If veteran, name war — Name Not 1

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rose M. Hunt

6 (c) If alive, give age years

7. Birth date of decreased (mo., day, yr.) 12/7/1896

8. AGE: Years 51 Months 10 Days — If less than one day hr. min.

9. Birthplace La Salle Ill. (Town, county, and state)

10. Usual Occupation Policeman

11. Industry or business Baltimore City

FATHER 12. Name John Kavanaugh

FATHER 13. Birthplace Ill

MOTHER 14. Maiden Name Mary Tyler

MOTHER 15. Birthplace Penn

16 (a) Informant Mrs J.C. Kavanaugh

(b) Address 12-9 William St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 16 48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Ritchie Highway

18 (a) Funeral director Baker & Sons

(b) Address Pulaski Highway & Fillmore St.

19 OCT 14 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1948 at — M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/10 1948 to 10/12 1948 and that I last saw him alive on 10/12 1948.

Immediate cause of death

(a) Cerebral Hemorrhage — Duration 2 days

Due to (b) Cerebral Hypertension — Duration 2 weeks

Due to (c)

Other Conditions

(Including pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause for which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature O. B. Wells M. D.

Address 1279 William St Date signed 10/14/48

VS 1-50

G676538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G676538 Registered No.

124a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Elmtree Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Elmtree Street (If rural give location)
(e) Citizen of foreign country? Yes or No) If yes, name country

3 (a) FULL NAME WALTER CHOJNOWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	white	married

6 (b) Name of husband or wife May
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1904

8. AGE: Years	Months	Days	If less than one day
44	1	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Pipe Corker
11. Industry or business City employee

FATHER
12. Name Walter Chojnowski
13. Birthplace Poland

MOTHER
14. Maiden Name Salamina ?
15. Birthplace Poland

16 (a) Informant Mary Chojnowski
(b) Address 1511 Elmtree St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. S. Fralkowski
(b) Address 2007 Eastern Ave.

19 (a) Huntington Williams, M.D. (Date rec'd by registrar) Registrar

14 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 1948, 9.00a.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.
Fatty degeneration of liver

Due to

Other Conditions History of chronic alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at Work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed October 14, 1948

Causes of death clearly and legibly.

G67633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

207

G67633 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1379 Binder Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES MARTIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April

8. AGE: Years 34 | Months 6 | Days | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Harry Martin
13. Birthplace S. C.

MOTHER
14. Maiden Name Emma Smith
15. Birthplace S. C.

16 (a) Informant: Lucilue Martin
(b) Address 613 S. Charles Stree

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.M.E. Co Md

18 (a) Funeral director Isaiah L Branson
(b) Address 1050 Montgomery St Huntington Williams, Md

19 OCT 14 1948 (Date received by Registrar) (c) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1948, at 10.00PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Aortic Dilatation

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner M.D.
Date signed 10-13-48

VS 151

Fill out the causes of death clearly and legibly.

657640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town New Windsor
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frances O. Garber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/2/48

8. AGE: Years 0 | Months 0 | Days 12 | If less than one day hr. min.

9. Birthplace Frederick Md
(Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Wilbur Garber
13. Birthplace Md

MOTHER
14. Maiden Name Mildred Pittzel
15. Birthplace Md

16 (a) Informant Wilbur Garber
(b) Address New Windsor, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-48 (month) (day) (year)
(c) Cemetery or crematory Wingard
Location Unionville, Fred. Co. Md.

18 (a) Funeral director C. M. Wantz
(b) Address Winfield Md.

19 (a) OCT 14 1948 (Date rec'd by registrar) (b) Entering for Baltimore, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1948 at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8 1948 to 10/14 1948, and that I last saw h alive on 10/14 1948.

	Duration
Immediate cause of death: Aspiration Pneumonia	
Peritonitis	
Due to Gastrostomy	
Due to Tracheo Esophageal Fistula	

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J. L. Aponte

Address Mercy Hosp Date signed 10/14/48

J. L. APONTE, M.D.

G67642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G67642

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2823 Hampden Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 +
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2823 HAMPDEN AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Fahey

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

20. DATE OF DEATH Oct 12 1948 8:30 A M

6 (b) Name of husband or wife MICHAEL J.
6 (c) If alive, give age years

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

7. Birth date of deceased (mo., day, yr.) DEC 21 1883

8. AGE: Years	Months	Days	If less than one day
64	9	21	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and State)
10. Usual Occupation HOUSEWIFE
11. Industry or business SELF

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

FATHER
12. Name SAMUEL BLAKE
13. Birthplace BALTIMORE MD.

MOTHER
14. Maiden Name MARY CAVANAUGH
15. Birthplace BALTIMORE MD.

16 (a) Informant MRS ALICE McCAFFERY
(b) Address 326 W. 30th St.

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St.

19 (a) OCT 14 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

23. Signature Wm G Kerr M.D. Medical Examiner.
Date signed Oct 13, 1948

VS 151

G67642

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

Registered No. 67[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2907 Winchester Street
(c) Hospital or institution: 16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Winchester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH MAGDLEN EDELEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife James A. Edelen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1862

8. AGE: Years	Months	Days	If less than one day
86	5	5	hr. min.

9. Birthplace Bryantown, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Farrall
13. Birthplace Bryantown, Md.

MOTHER
14. Maiden Name Elizabeth Langley
15 Birthplace Bryantown, Md.

16 (a) Informant Mr. James L. Edelen
(b) Address 2907 Winchester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Bryantown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 14 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1948 at 1:55p M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 1944 to Oct 13 1948.
and that I last saw her alive on Oct 13 1948.

Immediate cause of death	Duration
Edema of lungs	18 hrs
Due to Fasting circulation	1 wk
Due to Arterio sclerosis	10 yrs +
Other Conditions Hypertension	20 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leo A. Wells M. D.
Address 4100 Edmondson Ave Date signed 10/14/48

VS 193

G67643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X 937

Registered No. G67643

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 S. Chapelgate Lane
(c) Hospital or institution: Ventnor Lodge
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Braddock Heights (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDGAR STONEBRAKER McCARDELL

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Abby T. Barnes McCardell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1875

8. AGE: Years	Months	Days	If less than one day
73	8	2	hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business Self

FATHER
12. Name Adrian C. McCardell
13. Birthplace Williamsport, Md.

MOTHER
14. Maiden Name Alforetta Knode
15. Birthplace Washington Co., Md.

16 (a) Informant Mr. Lee McCardell
(b) Address 4618 Wilmslow Rd., Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Frederick, Md.

18 (a) Funeral director HENRY E. CARTY CO.
(b) Address Frederick, Md.

19 (a) OCT 14 1948 (b) Huntington Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1948 at 3:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to October 1948. and that I last saw h/M alive on October 13 1948.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to Senility	?
Due to Arteriosclerosis, high blood pressure; chronic myo	?
Other Conditions, Carditis with degenera t, in	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin M. Borden M. D.
Address 2030 W. Fayette St Date signed 10/14/48

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67644

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

Registered No. G67644

Burke

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4606 White Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4606 White Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY JEFFERSON BROOKS, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mazie M. Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1886

8. AGE: Years	Months	Days	If less than one day
61	10	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Gen'l. Supt.
11. Industry or business Riggs Distler

FATHER
12. Name John T. Brooks
13 Birthplace Md.

MOTHER
14. Maiden Name Annie Reed
15 Birthplace Md.

16 (a) Informant Mrs. Mazie M. Brooks
(b) Address 4606 White Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 14 1948 (Date rec'd by registrar) (b) Entered for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14/1948, at 5.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1946, to 10/14 1948, and that I last saw him alive on 10/11 1948.

Immediate cause of death Cerebral Hemorrhage — Duration one hour.

Due to Hypertensive cardio-vascular disease.

Due to

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopay:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury

23. Signature D. J. Battaglia M.D.
Address Belair Rd. Fullerton Date signed 10/14/48

VS 150

G67645

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 ✓ Registered No. G67645

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 2
(c) Hospital or institution: DOA
West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 N. Calvert St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Johanna Hofmeister

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles T. Hofmeister

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 Feb. 1862

8. AGE: Years: 86 | Months: 8 | Days: 3 | If less than one day: hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Trendel
13. Birthplace Germany [redacted]

MOTHER
14. Maiden Name Johanna Stout
15. Birthplace Germany

16 (a) Informant Miss Dorothy Hofmeister
(b) Address 2711 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date received by Registrar) OCT 14 1948 (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Oct. 1948, at 5:05 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐, or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed 13 Oct. 1948

VS 151

667646

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667646 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dubiland + Rayner
(c) Hospital or institution:
West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County –
(c) City or town Harrisburg, Pa (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Derry St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Tillie Katzen

3 (b) If veteran, name war –
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Barnet

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace [redacted] Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business –

FATHER 12. Name Simons
13. Birthplace Russia

MOTHER 14. Maiden Name Rachad
15. Birthplace Russia

16 (a) Informant Hyman Bernstein
(b) Address 1206 Derry St. Harrisburg Pa

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-15-48 (month) (day) (year)

(c) Cemetery or crematory
Location Harrisburg Pa

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eastern Blvd

19 (a) OCT 15 1948 (Date rec'd by registrar) Huntingtown Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1948, at 2 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1948 to 10/14 1948 and that I last saw h[illegible] alive on 10/14 1948.

Immediate cause of death Cerebral Vascular accident — Duration

Due to. Hypertensive cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation –

Major findings of operation: –

of autopsy: –

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Goldstein

Address [redacted] Date signed 10/14/48

VS 150

X

667647

ES- 123727

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

929

667647 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5524 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Weintritt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of ~~husband or~~ wife Sophia
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 4, 1871

8. AGE: Years 77 | Months 0 | Days 10 | If less than one day: hr min.

9. Birthplace Vienna Austria
(Town, county, and state)

10. Usual Occupation Grave Attendant

11. Industry or business Holy Redeemer Cemetery

FATHER
12. Name Frances Weintritt
13. Birthplace ? Austria

MOTHER
14. Maiden Name Katherine Putz
15. Birthplace ? Austria

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (b) Date thereof 10/25/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 S. Paul St.

19 (a) OCT 15 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14 19 48 at 5:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 19 48 to 10-14 19 48 and that I last saw h im alive on 10-14 19 48

	Duration
Immediate cause of death: Postcerebral myocardial infarction	24 hrs
Due to: Hypertensive-Arteriosclerotic Heart Disease	5 yrs
Due to:	
Other Conditions: Cerebral thrombosis with left hemiplegia (include pregnancy within 3 months of death)	24 hrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

Date of operation
Major findings of operation:
of autopsy: As above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury.

23. Signature William H. Kirkland
Address Balto City Hosp Date signed 10-15-48

VS 150

67648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 667648

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2845 N. Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2845 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Strube

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband Gustav Strube

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 27th 1866

8. AGE: Years	Months	Days	If less than one day
81	9	17	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Grosse
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Ritter
15. Birthplace Germany

16 (a) Informant Mrs Claire S. Schradieck
(b) Address 2845 N. Calvert St

17 (a) Burial (b) Date thereof 10/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 OCT 15 1948 Huntington Williams M.D.
(Date rec'd by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14th 1948, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1940 to Oct 14 1948, and that I last saw her alive on Nov 14 1947

Immediate cause of death	Duration
Coronary thrombosis	3 hours
Due to Arteriosclerosis	10 years +
Due to	
Other Conditions Pernicious anemia	10 years.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify)
(e) Means of injury

23. Signature Alan Bernstein M. D.

Address 110 9 N Calvert St Date signed 10/14/48

G67649

Hospital Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

✓ G67649

Registered No.

The cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 8

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1820 E. Chase St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Dunlop B.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/19/48

8. AGE: Years | Months | Days | (If less than one day) hr. 5 min.

1 27th

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Benjamin Dunlop

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Hospital

18 (a) Funeral director

(b) Address

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1948 at 7:45 M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/19 1948 to 10/19 1948.
and that I last saw him alive on 10/19 1948

Immediate cause of death Prematurity

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Harris Jones M.D.

Address 3 Hill Date signed 10/20/48

VS 150

667650 SC - 48-21948 ✓ 667650

JL - 123474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1314 W. Mosher St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy-Lewis - Ruth Ann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1948.

8. AGE: Years	Months	Days	If less than one day
		2	hr min

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Zollie Long

13. Birthplace Md.

MOTHER

14. Maiden Name Ruth Ann Lewis

15. Birthplace Va.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Cremation (b) Date thereof 10-7-48 At 9.00 A.M.

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory B.C.H.

Location 4940 Eastern Ave.

18 (a) Funeral director

(b) Address

19 (a) OCT 15 1948 (b) Huntington Williams, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5, 1948, at 4.45 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 3 1948 to Oct. 5 48, and that I last saw him alive on Oct. 5, 1948

Immediate cause of death. Premature

Duration 2d (4h)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature William P. Kean M. D.

Address Balto City Hosp. Date signed 10-6-48

VS 150

G67651 BC-48-28988

AB-123299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G67651

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Gillis-Twin "A"

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 27-1948

8. AGE: Years | Months | Days | If less than one day: hr. min.
1

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Preston Gillis
13. Birthplace ?

MOTHER
14. Maiden Name Dorothy Commodore
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9-29-48 At 9.00 AM (month) (day) (year)
(c) Cemetery or crematory B.C.H.
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Hollins, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28- 1948 at 10.30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 9-27- 1948 to 9-28- 1948 and that I last saw h im alive on 9-28- 1948.

Immediate cause of death Prematurity — Duration 1 hr. (Life)

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William P. Kean M. D.
Address Baltimore City Hosp. Date signed 10-6-48

G67652

AB-122122 BT- 21070

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G67652 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Galaway, W. Va. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Bise

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 14- 1948

8. AGE: Years	Months	Days	If less than one day
	1	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Izie Mae Bise
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/7/48 at 9 a.m. (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hosp.
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington, W. Va. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1948 at 5.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14- 1948 to 9-27- 1948, and that I last saw her alive on 9-27- 1948

Immediate cause of death Prematurity — Duration 1 mo.

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William R. Kean M. D.
Address Baltimore City Hosp. Date signed 10-8-48

VS 159

G667653 BC-48-22223 ✓ G667653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 North Ann Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Jones (100842)

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: Female
5. Color or race: Negroe
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 10/6/48
8. AGE: Years ..... Months ..... Days ..... If less than one day ..... hr. 15 min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business .....

FATHER
12. Name Nathan Forster
13. Birthplace Maryland

MOTHER
14. Maiden Name Audrey Moore
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address 601 North Broadway

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory .....
Location .....

18 (a) Funeral director .....
(b) Address .....

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1948, at 2:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1948 to Oct. 6 1948, and that I last saw her alive on Oct. 6 1948.

	Duration
Immediate cause of death: Atelectasis	
Due to: Prematurity	
Due to:	
Other Conditions:	
(Include pregnancy within 3 months of death)	
Date of operation:	
Major findings of operation:	
of autopsy: Atelectasis	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M.
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Paul D. Bunn M. D.
Address The Johns Hopkins Hospital Date signed 10-7-48

VS 150

X

Please write the causes of death clearly and legibly. The information must be carefully supplied. Physicians: please write the causes of death clearly and legibly.

67654 SC-48-21540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

Registered No. 67654

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 Barclay, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Partlow (Partlow)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 15 hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Partlow

13. Birthplace ?

MOTHER 14. Maiden Name Lenia ?

15. Birthplace ?

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct- 9- 1948 at 4 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9 1948 to 10-9 1948 and that I last saw him alive on 10-9 1948.

Immediate cause of death	Duration
Cerebro Hemorrhage	
Apoplexia ?	
Due to ? cardiac Failure	
Due to	
Other Conditions	
(include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature John J. Ryan M.D.
Address Johns Hopkins Hosp. Date signed 10-10-48

VS 150

G67655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G67655

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Laurel
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-6-48

8. AGE: Years | Months | Days: 4 | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Melvin ? Thomas
13. Birthplace

MOTHER
14. Maiden Name Lula ? Woody
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1948, at 11 25A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1948 to 10/10 1948 and that I last saw h alive on 10/10 1948

Immediate cause of death: Atelactasis — Duration

Due to Prematurity

Due to

Other Conditions Cerebral Haemorrhage
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Hamp M. D.
Address Johns Hopkins Hosp Date signed 10-11-48

VS 150

159

667656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1228

Registered No. 667656

Type or print plainly in ink. Fill all blanks. Report cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Druid Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Dyson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Carter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Albert Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1885

8. AGE: Years 63 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Mary E. Campbell
15. Birthplace Washington D.C.

16 (a) Informant Mrs Elenora Dudley
(b) Address 623 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16 1918 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director Mrs Frances E. Howard
(b) Address 578 W. Biddle St. Baltimore Md.

19 OCT 15 1918 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1918 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1918 to 10/13 1918 and that I last saw h[illegible] alive on 10/13 1918.

Immediate cause of death: Complete interstitial Pneumonia — Duration

Due to: Arteriosclerosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P.M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature E. C. Walden-Lee M. D.
Address [illegible] Date signed Oct 15 1918

E. C. Walden-Lee

VS 193

6676:57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

6676:57 Registered No.

Type or print the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 30 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1541 Light Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MIRANDA L. WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife John P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2-11-1884

8. AGE: Years	Months	Days	If less than one day
64	8	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER	12. Name	Isaac Manning
	13. Birthplace	Balto
MOTHER	14. Maiden Name	Louisa Barwick
	15. Birthplace	Md

16 (a) Informant Dolores Wilson
(b) Address 1541 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Elkridge, Md.

18 (a) Funeral director George D. Farley
(b) Address Fulton ave & Fayette St.

19 OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1948 at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12 1948 to 10-13 1948 and that I last saw her alive on 10-13 1948

Immediate cause of death	Duration
Pulmonary Edema	3 days
Due to Cardiac Decompensation	4 yrs
Due to Hypertensive Cardiovascular Disease	10 yrs
Other Conditions Carcinoma of Uterus Lupema, Rigal Thigh (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: No CVD - Decompensation Ca of Uterus

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward A. Newell M. D.
Address 1213 Light St. Date signed 10-15-48

VS 155

576:58 BC - 48 - 22065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66576:58 11012

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church home + hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No 2803 Liberty Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Harris

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/29/48

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 0 hr. 45 min.

9. Birthplace Church Home + Hospital Balt. 31 Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Newborn

FATHER
12. Name Sterling Harris
13. Birthplace ?

MOTHER
14. Maiden Name Rosalee Grooms
15. Birthplace Virginia

16 (a) Informant mother
(b) Address 2803 Liberty Parkway Dundalk 29 Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 1 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 15 1948 (Date rec'd by registrar) Huntington Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30/48 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11:5 PM 9/29 1948 to 12 M 9/30 1948, and that I last saw her alive on 12 M 9/30 1948.

Immediate cause of death atelectasis — Duration

Due to bilateral pleural effusion

Due to unknown (Hydrops fetalis)

Other Conditions peritoneal effusion

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Robert Haase M. D.
Address Church Home + Hosp. Date signed 9/30/48

VS 150

67659 BC-48-10463 ✓ 67659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

Registered No. 67659

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 W. Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THERESA MAE COATES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1948

8. AGE: Years	Months	Days	If less than one day
	6	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lorenzo Brodie, Jr.
13. Birthplace Franklin Co., N.C.

MOTHER
14. Maiden Name Margaret Coates
15. Birthplace Calvert Co. Md.

16 (a) Informant: Margaret Coates
(b) Address 1504 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 3929 W. Lombard St. Lemuel Williams, M.D.

19 (a) OCT 15 1948 (Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1948, at 8 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uppper Respiratory Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Kyle M.D. Medical Examiner.
Date signed 10/13/48

VS 151

67760 Ba-48-22083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No. 67760

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles St (18)
(c) Hospital or institution:
Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Wilmington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Batch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Five hours 10/7/48

8. AGE: Years	Months	Days	If less than one day
			5 hrs. 2 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Leroy Batch
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Jessie Rena Davison
15 Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 11 1948

18 (a) Funeral director Commissioner of Health
(b) Address
OCT 15 1948

19 (a) (Date rec'd by registrar) (b) Registrar Baltimore, Md.

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1948, at 34 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7- 1948, to 10-8- 1948 and that I last saw h alive on 10-8 1948

Immediate cause of death Hydrocephalus
Due to Congenital
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature Jones Hopkins M. D.
Address 876 Wilmington Ave. Date signed 10/7/48

667661

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82a

667661
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Rd.
(c) Hospital or institution:
Beach Hill Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 E. 20th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATE HOWARD RILEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1872

8. AGE: Years	Months	Days	If less than one day
76	6	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Benjamin Clay Howard Riley
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eliza Jane Hamilton
15. Birthplace Seaford, Delaward

16 (a) Informant Miss Bertha Creamer
(b) Address 1008 E. 20th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

OCT 15 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1948, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1948 to Oct 13 1948, and that I last saw her alive on Oct 12 1948.

Immediate cause of death Cerebral Hemmorhage — Duration 5 days
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evl Smith
Address 1223 E North Ave Date signed 10/14/48
M D

67662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. 67662

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3603 Caton Ave. at Monastery Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Caton Ave. at Monastery Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY THERESA ROSENBERGER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-10-7139

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1879

8. AGE: Years 69 | Months 2 | Days 19 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Saleslady

11. Industry or business Hochschild, Kohn & Co.

FATHER
12. Name Appolina Rosenberger
13. Birthplace Md.

MOTHER
14. Maiden Name Wilhelmina Karl
15. Birthplace Md.

16 (a) Informant Mr. Charles W. Altvater
(b) Address 3603 Caton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto. Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Md.

19 OCT 15 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1948, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7, 1948, to Oct. 14, 1948, and that I last saw her alive on Oct. 13, 1948.

Immediate cause of death: Carcinoma of lungs — Duration: 10 mo
probably of ovarian origin

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A. Kump M. D.
Address 3030 Edmondson Ave. Date signed 10/15/48

VS 150

Enter age if especially important. Physicians: please write the causes of death clearly and legibly. Apply rubber stamp if available.

667663

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

121a

Registered No. 667663

Please write plainly and fill in all blanks. Use ink or typewriter. Spell out all words. Do not abbreviate. Write in the words and figures required. Do not leave blanks. If none, write none. If unknown, write unknown. Be sure to answer every question. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3004 Brighton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Brighton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SALLIE KATE ASKINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife William C. Askins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1867

8. AGE: Years	Months	Days	If less than one day
81	3	14	hr. min.

9. Birthplace Warsaw, Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard R. Webb
13. Birthplace Virginia

MOTHER
14. Maiden Name Fannie A. Yeatman
15. Birthplace Virginia

16 (a) Informant Mr. William C. Askins, Son
(b) Address 3004 Brighton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 OCT 15 19... (Date received by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1948, at 8A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1948. to Oct 14 1948, and that I last saw h alive on Oct 6- 1948

Immediate cause of death Coronary occlusion — Duration 7 hrs

Due to Arteriosclerosis — 5 yrs

Due to Chr. nephritis — 5 yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide no
(b) Date of occurrence ... at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. McDermett M. D.
Address 1136 Poplar Grove St. Date signed 10/15/48

VS 150

67664 ✓ 67664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Please write clearly and legibly. Use ink or indelible pencil. Do not use abbreviations. If the exact date of death is unknown, the coroner must fix the date.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 143 W. Henrietta
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 143 W. Henrietta (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie M. McIver

3 (b) If veteran, name war: Ware 2
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Leda McIver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24-1906

8. AGE: Years	Months	Days	If less than one day: hr.	min.
42	8	20		

9. Birthplace Macon. Ga. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Neal McIver
13. Birthplace N.C.

MOTHER
14. Maiden Name Virginia Blank
15. Birthplace N.C.

16 (a) Informant Leda McIver
(b) Address 143 W. Henrietta

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18-48 (month) (day) (year)
(c) Cemetery or crematory Sanford. N.C.
Location Lee Co

18 (a) Funeral director James A Hayes
(b) Address 142 W. Hill St

19 (a) OCT 15 1948 (Date received by registrar) (b) Huntington Hillsman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1948 at 11.15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 10/4/48 19 to 10/14 1948, and that I last saw h[illegible] alive on 10/14 1948.

Immediate cause of death	Duration
Coronary Thrombosis	10/14
Due to Myocarditis	
Due to Arteriosclerosis	10 yr
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert R Lefevre M. D.
Address 122 W. Bmore St Date signed 10/15/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G677665

767

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No 1 Alexander Ave Catonsville
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lenard Webb Stephens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	negro	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-8-48

8. AGE: Years	Months	Days	If less than one day
		1½	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Enoch Webb
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Viola Watkins
15. Birthplace Baltimore, Md

16 (a) Informant Viola Watkins Stephens
(b) Address No 1 Alexander Ave. Catonsville Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc Johns Hopkins Medical School OCT 14 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) 10-11-1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/9 1948, at 1.57 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8 1948, to 8/9 1948, and that I last saw h alive on 8/9 1948.

Immediate cause of death: Asphyxia — Duration

Due to: Respiratory Failure

Due to: Undetermined Etiol.

Other Conditions: Congen. Blood Dyscrasia

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sam. H. Rawlston M. D.

Address Provident Hosp Date signed 8-20-48

VS 150

161a

67676 BC-48-21776 ✓ 67676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 67676

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lenden Ave. & Madison St.
(c) Hospital or institution: Maryland Steil Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 1
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1846 North Bay St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Infant Hahn

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
—	—	Fe	W	S

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 Oct. 1948

8. AGE: Years | Months | Days | If less than one day: 4 hr. 31 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Boyd Lenore Hahn
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Abbie Elizabeth Cap
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elizabeth Hahn
(b) Address 1846 North Bay St. #15

17 (a) — (Burial, cremation, or removal) (b) Date thereof — (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School OCT 14 1948

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 14 1948 (Date received) Registrar, Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1948 at 10:36 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1948 to Oct 3 1948, and that I last saw her alive on Oct 3 1948.

Immediate cause of death	Duration
Prematurity	
Due to (Mother's unsupport and abruptio placenta)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature W. C. Friday, M. D.
Address Maryland Steil Hosp. Date signed 10-3-48

VS 180

X

766273C = 48-18332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G67607 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 N Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johnette Gwendolyn Fowlkes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/26/48

8. AGE: Years	Months	Days	If less than one day
			24 hr. 10 min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation N' Born Infant
11. Industry or business

FATHER
12. Name John Fowlkes
13. Birthplace Crewe Va

MOTHER
14. Maiden Name Lucy Mae Gill
15. Birthplace Oxford NC

16 (a) Informant Miss Lucy Mae Gill
(b) Address 1024 N Eden St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loca Johns Hopkins Medical School OCT 14 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 5 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1948 at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1948 to 8/27 1948, and that I last saw h[illegible] alive on 8/27 1948.

Immediate cause of death Questionable Circumstances — Duration
Due to Aspiration
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Provident Hosp (Date signed)

8-30-48

VS 180

Office use is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

67668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 67668

Registered No. 12B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 686 Pearse St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 686 Pierce St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Blanche Sharp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Isaac Sharp

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Geo Freman

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Dyson

15. Birthplace Maryland

16 (a) Informant Agnes Thomas

(b) Address 686 Pearse St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)

(c) Cemetery or crematory St Peters

Location Balto City

18 (a) Funeral director Wm A Jackson

(b) Address 916 Rumb Ave

19 (a) OCT 15 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1948. at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5, 1948. to Oct. 13, 1948. and that I last saw her alive on Oct. 12, 1948.

Immediate cause of death: Pulmon. Tuberculosis — Duration: 3 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature McDonald Bando M. D.

Address 2445 W. Hill Ave Date signed 10-15-48

VS 153

7669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 16765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 E. 23rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City, or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 E 23rd St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Hawthorne

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Joseph T
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1896

8. AGE: Years	Months	Days	If less than one day
52	3	20	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Laundress
11. Industry or business

FATHER	12. Name John W Jones
	13. Birthplace Md
MOTHER	14. Maiden Name Mary Jones
	15. Birthplace Md

16 (a) Informant Joseph Hawthorne
(b) Address 415 E 23rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A A County
18 (a) Funeral director Mrs Pott A. Elliott Dyer
(b) Address 1297 N. Carey St
19 (a) Oct 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1948 at 7:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1948 to Oct 12 1948 and that I last saw her alive on Oct 12 1948

Immediate cause of death Coronary Thrombosis — Duration 2 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature R. Garland Schmidt
Address 1534 Druid Hill Ave Date signed Oct. 13-48

VS. 150

G67670

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67670 Registered No. 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Canton & Milton
(c) Hospital or institution:
St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town (and) Daniels, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Baby Boy Nealy

3 (b) If veteran, name war: (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	C.

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-6-48

8. AGE: Years — Months — Days — If less than one day 0 hr. 5 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Luther Nealy
13. Birthplace Penn.

MOTHER
14. Maiden Name Bobbie Burke
15. Birthplace Va.

16 (a) Informant Bobbie Nealy
(b) Address Daniels Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director Martin Bailey & Sons
(b) Address 827 W. North Ave.

OCT 15 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1948 at 11:35 M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/6 1948 to 10/6 1948, and that I last saw him alive on 10/6 1948

Immediate cause of death: Cardio-Resp failure — Duration
Prematurity (4½ mo)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence F. Elinor M.D.
Address St Agnes Hosp Date signed 10/12/48

G67671 ✓ G67671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1328 West Balto. Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 West Balto Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ottomar Toepfer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of ~~husband~~ or wife TERESA BERTA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 30, 1885

8. AGE: Years	Months	Days	If less than one day
63	5	16	hr. min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual Occupation MACHINIST

11. Industry or business MD. DRY GOOD

FATHER
12. Name ANDREAS TOEPFER
13. Birthplace GERMANY

MOTHER
14. Maiden Name CATHERINA KOCH
15. Birthplace GERMANY

16 (a) Informant MRS OTTOMAR TOEPFER
(b) Address 1328 BALTIMORE AVE

17 (a) BURIAL (b) Date thereof OCT 18 '48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SALEM LUTHERAN
Location CATONSVILLE MD

18 (a) Funeral director Wm H Wilson
(b) Address 4101 Edmondson Ave

19 (c) OCT 15 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1948 at 2 10 P M

21. I certify that I took charge of the remains described above, held an Aut & Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiac Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Kelbert M.D.
Medical Examiner.
Date signed Oct 15, 1948

VS 151

G67672

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67672

Registered No. 9-D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~785 Crantley St~~
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 785 CRANTLEY ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary O'Donnell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband ~~or wife~~ late THOMAS P

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 29, 1872

8. AGE: Years	Months	Days	If less than one day
76	5	15	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name PATRICK KANE
13. Birthplace IRELAND

MOTHER
14. Maiden Name BRIDGET ODONNELL
15. Birthplace IRELAND

16 (a) Informant MISS ETHEL ODONNELL
(b) Address 785 CRANTLEY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 18 '48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Harry H Wilkes
(b) Address 401 Edmondson Ave

19 (a) 10-18-1948 (b) (Registered by registrar) Registrar
Huntington Athletic Club

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1948 at 5-45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8 1948 to 10/14 1948. and that I last saw her alive on 10/13 1948.

Immediate cause of death Respiratory failure

Due to cerebral damage

Due to arteriosclerotic H. D.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D S Knowles M. D.
Address Bon Secours Hosp Date signed 10/14/48

667673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 4813

Registered No. 667673

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 W. Lafayette ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) 5 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 W. Lafayette ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Oliviea Walker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Sam Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name George Blunt
13. Birthplace N. C.

MOTHER
14. Maiden Name Sylvia Harvey
15. Birthplace N. C.

16 (a) Informant Horace Blunt
(b) Address 702 W. Lafayette ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)

(c) Cemetery or crematory Bell Haven
Location Bell Haven N. C.

18 (a) Funeral director Geo. A. Kelson
(b) Address 1303 Pennsylvania ave

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14-1948, at 5.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2-1948, to 10-14-1948, and that I last saw h[illegible] alive on 10-11-1948.

Immediate cause of death Carcinoma of uterus — Duration unknown

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Nature of injury

23. Signature Jno. M. Campbell M. D.
Address 6 W-H, Carolina Date signed 10-15-48

VH 3

G67674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G67674

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 Seagull ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1
(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Cherry Hill Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Seagull ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Grant

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-1993

4. Sex Male

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8-1898

8. AGE: Years 50 Months 6 Days 5 If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business First Nat. Bank

FATHER 12. Name Sandy Grant

13. Birthplace Virginia

MOTHER 14. Maiden Name Cindra Derick

15. Birthplace Culpeper Co Va

16 (a) Informant Bertha Greene

(b) Address 403 Seagull ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1001 Bloomingdale ave

19 (a) OCT 15 1948 (Date rec'd by registrar) Huntington Woods, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1948 12:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1948 to Oct 13 1948. and that I last saw him alive on Oct 12 1948

Immediate cause of death Lobar Pneumonia (unresolved)

Duration 43 days

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Haines M.D.

Address 507 N Hamburg st Date signed 10/14/48

VS 15

G67675 Vol 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1216

Registered No. G67675

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 103 S. Caroline St (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Cornish

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-95

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Gross
13. Birthplace Md

MOTHER 14. Maiden Name Delia Cottman
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy E. Wilson
(b) Address 1010 Bentley Ave

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13 1948 at 7 00 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 1948 to 10-13 1948 and that I last saw her alive on 10-13 1948

Immediate cause of death Cardiac failure with pulmonary edema & uremia

Due to hypertensive cardio vascular disease and chronic glomerulo nephritis

Duration

Other Conditions Type II Diabetes
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of autopsy Hypertrophy heart and small scarred kidneys

PHYSICIAN

(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature John Calvin Harvey M.D.
Address Johns Hopkins Hospital
10-13-48

VS 150

657676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82

Registered No. 657676

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 E Fairmount Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME BEATRICE GRAY MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	married

6 (b) Name of husband or wife Langford Miller
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1908

8. AGE: Years	Months	Days	If less than one day
39	11	18	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Richard A. Gray
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name Georgia Vinson
15. Birthplace Essex Co., Virginia

16 (a) Informant Langford Miller
(b) Address 1520 E. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy B. Wilson
(b) Address 1000 Bloomsbury ave

19 (a) OCT 15 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 1948, 6.30p.M

21. I certify that I took charge of the remains described above, held an Inspec & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asymptomatic

Due to SYNCOPE

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed October 14, 1948

VS 1st

667677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12-7a

Registered No. 667677

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 W Chase St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 522 Normandy ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Henry Zepp

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 13-1872

8. AGE: Years 76 | Months | Days 1 | If less than one day: hr. min.

9. Birthplace Hampstead Carroll Co. Md. (Town, county, and state)

10. Usual Occupation Salesman United

11. Industry or business Sanitary Co

FATHER 12. Name George W Zepp
13. Birthplace Hampstead Carroll Co

MOTHER 14. Maiden Name Mary Jamison
15. Birthplace Hampstead Carroll Co

16 (a) Informant Mrs Lola M. Zepp
(b) Address Leverod Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17 1948 (month) (day) (year)
(c) Cemetery or crematory Wesley Cemetery
Location Hampstead Carroll Co Md

18 (a) Funeral director Maurice Cook Lyfer
(b) Address 1600 W. North ave.

19 (a) OCT 15 1948 (Date rec'd by registrar) Lemington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14-48 19 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1946 to 10-14 1948, and that I last saw h in alive on 10/13 1948

	Duration
Immediate cause of death: Terminal Pneumonia —	
Due to: Pulmonary edema —	
Due to: Arteria —	
Other Conditions: hypertrophy of prostate (Include pregnancy within 3 months of death)	2 years

Date of operation. 10/12/48

Major findings of operation: hypertrophy of prostate

Autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature H Walker Edmonds
Address 39 21 Date signed 10/14/48

VS 150

676678 RAHNIS 676678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 200a

Registered No. 676678

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Leuvenberg Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Cape May. (If outside city or town limits, write RURAL and give town)
(d) Street No. Cape May Rd. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN H RAHNIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Emilie Rose Uebelmesky

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug. 15-1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71	1			

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business —

FATHER
12. Name Herman Rahnis
13. Birthplace Germany.

MOTHER
14. Maiden Name Louise Holland
15. Birthplace Balto.

16 (a) Informant Mrs. Emilie Rahnis
(b) Address Cape May Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer. Location Belair Rd.

18 (a) Funeral director John D Connelly.
(b) Address 48 Eastern Ave. Essex 21.

19 OCT 15 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1948, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1948, to 10-14 1948, and that I last saw h alive on 10-14 1948.

Immediate cause of death	Duration
Cardio vascular respiratory failure	
Due to Peripheral circulatory collapse	
Due to Cause undetermined	

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature W. A. Oberdeerner M. D.
Address Leuvenberg Hosp Date signed 10.14.48

VS 150

Dr. E. J. Alessi

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

512

✓ 667679

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3010 Westfield Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3010 Westfield Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD A. SANDKUHLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Clara M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1882

8. AGE: Years	Months	Days	If less than one day
66	0	29	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Henry Sandkuhler
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Augusta ?
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Clara Sandkuhler
(b) Address 3010 Westfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Date received by local registrar OCT 19 1948 (b) Huntington Hollins Mo. REGISTRAR

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1948, at 1:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 1936 to Oct 14 1948.
and that I last saw h alive on Oct 14 1948.

Immediate cause of death Carcinoma of the Prostate with metastases

Due to arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration hrs. 1948

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature E. J. ALESSI, M.D.
Address 6217 Harford Rd Date signed 10/14/48

VS 150

67680 Keown
1938 Linden Avenue

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 67680

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 Callow Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 Callow Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A. Scholz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife William E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 25, 1875

8. AGE: Years	Months	Days	If less than one day
72	11	20	hr. min.

9. Birthplace Mc Keeskock, Pa. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Mildred Mc Mullen
(b) Address 2300 Callow Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15th 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to 15-Oct 1948, and that I last saw h[illegible] alive on 14 Oct 1948

Immediate cause of death: Cerebral Hemorrhage (Duration: Oct 2 '48)
Due to Rt Hemiplegia
Due to Hypertensive Arteriosclerotic Cardio Vascular Disease (Duration: years)
Due to (Duration: years)
Other Conditions: Called Gastric
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury
23. Signature Saunton L. Brown Jr. M.D.
Address 1938 Linden Ave Date signed 15 Oct 48

VS 153

BC-48-16492 ✓ 667681

667681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3806 Southern Ave.
(c) Hospital or institution: West Balto. Gen. Hosp. or
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3806 Southern Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Ray SUSAN IRENE REY

3 (b) If veteran, name war — no
3 (c) Social Security Account No. — no

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Oct 1948 at 3 P.M.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1948 to Oct 15 1948 and that I last saw h[er] alive on 15 Oct 1948.

Immediate cause of death Atelectasis & Causes pulmonary aspiration of food.

Due to Causes unknown.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/29/48

8. AGE: Years 0 | Months 2½ | Days 17 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John H Rey
13. Birthplace Maryland

MOTHER
14. Maiden Name Emily Ray
15. Birthplace Penna

16 (a) Informant John Howard Rey
(b) Address 3806 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16, 48 (month) (day) (year)

(c) Cemetery or crematory Woodland
Location Taylor ave Balto. Md.

18 (a) Funeral director Leonard J. Rund
(b) Address 5305 Hurdis Rd.

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. A. E. Young
Address W.A.E. Young Date signed 15 Oct 48

VS 150

H 2 5

G67682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125a

Registered No. G67682

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Raspeburg (If outside city or town limits, write RURAL and give town)

(d) Street No. 1225 Rustic Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Wiegmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Mary E. Wiegmann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17 96 76

8. AGE: Years	Months	Days	If less than one day
72	2	26	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Brick Layer

11. Industry or business

FATHER 12. Name William Wiegmann

13. Birthplace ? Germany

MOTHER 14. Maiden Name ?

15 Birthplace ? Germany

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16-48 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem. Location Eastern Ave.

18 (a) Funeral director John A. Miller

(b) Address 2304 Jefferson St.

19 (a) OCT 15 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1948, at 10 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2 1948 to 10-13 1948. and that I last saw him alive on 10-13 1948.

Immediate cause of death	Duration
Pulmonary embolism	
Due to Bilateral thrombo-phlebitis	
Due to Cancer of urinary bladder	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct. 2, 1948

Major findings of operation: Perforation of urinary bladder and peritonitis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Richard F. Kieffer Jr.

Address Johns Hopkins Hosp. Date signed 10/15/48

VS 130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 66[illegible]3

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Gwendolyn Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-28-48

8. AGE: Years	Months	Days	If less than one day
		5-4	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Reid
13. Birthplace Waynesboro, S.C

MOTHER
14. Maiden Name Magola Irma Dixon
15. Birthplace Hightport N.C

16 (a) Informant Magola Dixon
(b) Address 1631 W Lexington St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 13 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 15 1948 (Date rec'd by registrar) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1948, at 7:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28 1948, to 10-2 1948, and that I last saw her alive on 10-2 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity	
Due to unknown cause	
Other Conditions Clinical Jaundice	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. A. Peterson M. D.

Address University Hosp Date signed 10-5-48

X

67684 C-48-2165 159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67684

The following items must be accurately supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Lake Shore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pasadena
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-30-48

8. AGE: Years	Months	Days	If less than one day
			8 hr. 35 min.

9. Birthplace University Hospital (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Edward Hawkins
13. Birthplace ?

MOTHER
14. Maiden Name Anna Clementine Mills
15. Birthplace Curtis Bay, Md.

16 (a) Informant Anna Hawkins, Mother
(b) Address Lake Shore Pasadena, Md

17 (a) (Burial, cremation, or removal) **(b) Date thereof** (month) (day) (year)
(c) Cemetery or crematory
Location [illegible] OCT 7 - 1948

18 (a) Funeral director
(b) Address

Commissioner of Health

19 (a) OCT 15 1948 (Date rec'd by registrar) **(b)** [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1 1948, at 12:xxPM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1948, to 10-1 1948, and that I last saw h— alive on 9-30 1948.

Immediate cause of death 30 week old premature infant

Due to Asphyxiation - respiratory failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben Ford M.D.
Address [illegible] Date signed 10-1-48

VS 150

67685 BC-HP-21665

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159 ✓ Registered No. 66[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood Sts.
(c) Hospital or institution: Univ. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
681 Sarah Anne St
(d) Street No. ~~Emmettsburg Hosp.~~ (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Hall

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-3-48

8. AGE: Years | Months | Days | If less than one day 6 hr. 40 min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name [illegible] ?

13. Birthplace (~~Northampton~~) ?

MOTHER 14. Maiden Name Mary Hall

15. Birthplace Washington, D.C.

16 (a) Informant Mary Hall
(b) Address 681 Sarah Anne St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/4/48 (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 7 - 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3/48 1948, at 1:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1948, to 10-3 1948 and that I last saw her alive on 10-3 1948.

Immediate cause of death Cardio-Resp. Failure
Due to Prematurity

Duration 6 hrs 40 min

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Auld M. D.

Address Univ Hosp Date signed 10-4-48

VS 150

X

67686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 Belair Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: JOHN HINDAS KENNEDY

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Maude (Erdman) Kennedy

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1879

8. AGE: Years	Months	Days	If less than one day
69	8	0	hr. min.

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation Monument

11. Industry or business

FATHER
12. Name Hugh T. Kennedy
13. Birthplace Scotland

MOTHER
14. Maiden Name Elizabeth M. MacLean
15. Birthplace Scotland

16 (a) Informant Mrs. Maude E. Kennedy
(b) Address 2008 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1948, at 5:18PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malecio M.D. Medical Examiner.
Date signed 10/15/48

VS 151

667687

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

9-B

Registered No. 667687

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fairmount & Wakeland
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 Booth St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Torst

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Col.	Married

6 (b) Name of husband or wife Engelbert Torst
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1904

8. AGE: Years	Months	Days	If less than one day
44	5	10	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name George Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Margarete Focher
15. Birthplace Germany

16 (a) Informant Engelbert Torst
(b) Address 2201 Booth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md.

18 (a) Funeral director George [illegible]
(b) Address 1401 Frederick Ave

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Oct 1948 at 6:39 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 12 Oct 1948 to 14 Oct 1948
and that I last saw h[illegible] alive on 13 Oct 1948

Immediate cause of death	Duration
(a) Mitral Stenosis Rheumatic heart disease.	
Due to (b) Rheumatic fever.	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Young M.D.
Address 4 E. Biddle St. Date signed 10-15-48

VS 150

Write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 667,588

CERTIFICATE OF DEATH

48-225 93 160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eutaw and Baynes sts
(c) Hospital or institution:
West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5242 Long Point Rd #22 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Horsey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Woodrow Horsey
13. Birthplace Ellicott City Md.

MOTHER
14. Maiden Name Virginia Mary Taylor
15. Birthplace Ellicott City Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 11 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williamsport Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Oct 1948 at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1948 to 10/2 1948, and that I last saw him alive on 10/2 1948.

Immediate cause of death Intra cranial hemorrhage — Duration 2 days

Due to Unknown cause

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 10/2/48

Major findings of operation: X ray of head showed spinal fluid in spinal tap

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. P. Young M.D.
Address West Balto. West Balto Date signed 10/3/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. BC-48-2385 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland + Raymon Ave
(c) Hospital or institution: West Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 hrs 44
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 Westwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years | Months | Days | If less than one day 5 hr. 31 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Robinson
13. Birthplace Mary-D, Penna

MOTHER
14. Maiden Name Rosemarie Corriere
15. Birthplace Balto, Md.

16 (a) Informant Mrs Rosemarie Robinson
(b) Address 2204 Westwood Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School OCT 4 - 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 15 1948 (Date rec'd by registrar) (b) Hunting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1-48 19 at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30-48 19 to 10-1-48 19 and that I last saw her alive on 10-1-48 19

Immediate cause of death resp failure — Duration

Due to premature

Due to

Other Conditions Myo fib (1) Hydramnios (2) Pre-eclampsia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Grayson S Waldorf M. D.
Address WJ 3-4 Date signed 10-1-48

VS 150

67690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159 ✓ Registered No. 67690

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University of Maryland Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 South Paca St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Coffman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-19-48

8. AGE: Years	Months	Days	If less than one day
	1	45	15 hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Coffman
13. Birthplace Virginia

MOTHER
14. Maiden Name Beulah Coffman
15 Birthplace Virginia

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 7 - 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 3 1948, at 4.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 1948, to 10-3 1948, and that I last saw her alive on 10-3 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Galloway, M. D.
Address University Hospital Date signed 10-3

VS 150

G67691

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

518

Registered No. G67691

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 Baltic Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Baltic Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter William Payne

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
	213-05-8956	M	W	M

6 (b) Name of husband or wife Evelyn M. (Clowes)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/5/1893

8. AGE: Years	Months	Days	If less than one day
55	0	6	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business Locke Insulator Co.

FATHER
12. Name Walter Payne
13. Birthplace Eng.

MOTHER
14. Maiden Name Agnes Lythgoe
15. Birthplace Eng.

16 (a) Informant Family
(b) Address Same

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Dorsey, Maryland

18 (a) Funeral director James L. McCauley
(b) Address 130 East Fort Avenue

19 (a) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1948, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/21 1948 to 10/13 1948, and that I last saw h[illegible] alive on 10/7 1948.

Immediate cause of death	Duration
Pulmonary Edema	1 day
Due to General Congestion	
Due to Coronary Thrombosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James W. Baltzenberger M. D.
Address 22 N. National Ave. Date signed 10/15/48

VS 150

657692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 657692

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3527 Hayward Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3527 Haywards Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Evans B. Bowling

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-24-0064

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife Lorman M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 6, 1918

8. AGE: Years 30 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Llewellyn Cross
13. Birthplace Canada

MOTHER
14. Maiden Name Mary Lindner
15. Birthplace Balto. Co. Md.

16 (a) Informant Lorman M. Bowling
(b) Address 3527 Hayward Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Lamm Bros
(b) Address 5005 Park Heights Ave

19 OCT 15 1945 (Date received by Registrar) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1945, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1945 to Oct 14 1945; and that I last saw h[illegible] alive on Oct 13 1945.

Immediate cause of death Cerebral Hemorrhage — Duration Sudden

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. L. de Barbieri M. D.
Address 4723 Park Heights Ave. Date signed 9/15/45

VS 150

G67693

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

477

G67693 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2634 Matthew Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Sadie A. Dowd.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband or wife Mr. Thomas F. Dowd.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 26, 1894

8. AGE: Years	Months	Days	If less than one day
54.	7	15	20 hr. — min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George S Limpert
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Bigan
15. Birthplace Baltimore

16 (a) Informant Records
(b) Address Union Memorial Hospital

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 OCT 16 1948 (Date rec'd by registrar) Huntington for Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1948, at 7:A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1948 to Oct 15 1948, and that I last saw h[illegible] alive on Oct 15 1948.

Immediate cause of death Respiratory Failure — Duration ?
Carcinoma of Lung

Due to Carcinoma of Lung — Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James McC. Finney M. D.
Address Union Memorial Hospital Date signed 10-15-48

VS 150

67694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 67694

1. PLACE OF DEATH:
(a) Baltimore City; Maryland
(b) Street address 1911 Harlem Ave.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 Harlem Ave. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME WYSOR REAVLY WAYNESBORO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Gordon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 28, 1887

8. AGE: Years	Months	Days	If less than one day
61	3	15	hr. min.

9. Birthplace Charleston, W. Virginia
(Town, county, and state)

10. Usual Occupation Hpusewife

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant Mr. Gordon Waynesboro
(b) Address 1911 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48. (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co. Maryland.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) OCT 16 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1948, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1948 to 10-13 1948. and that I last saw h alive on 10-13 1948.

Immediate cause of death Myocardial Degeneration — Duration 2wk.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Lindsay M.D.
Address 1343 Penna. Ave Date signed 10/13/48

VS 193

50 - C - 18107

67695 McKenney

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

Registered No. G67695

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days.
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N Arlington Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Henry McKenney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1945

8. AGE: Years	Months	Days	If less than one day
3	8	14	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation child.

11. Industry or business

FATHER
12. Name John Henry McKenney
13. Birthplace Lancaster Co. Penna.

MOTHER
14. Maiden Name Viola Gladden
15. Birthplace St Marys Co. Md

16 (a) Informant parents
(b) Address 519 N. Arlington Ave. Balto 23.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) OCT 16 1948 (Date rec'd by registrar) (b) Huntingtown Calvert Co. Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14/48 1948, at 245 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 1948, to Oct 14 1948, and that I last saw him alive on Oct. 13 1948.

Immediate cause of death	Duration
Tuberculous Meningitis	2 weeks.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P.A. Benson M. D.
Address Sydenham Hospital Date signed 10/14/48

V S 150

X

667696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186B

Registered No. 667696

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #16 Box 76 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM J. MAGSAMEN

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 215-14-8411

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Virginia M. Magsamen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 18, 1924

8. AGE: Years	Months	Days	If less than one day: hr.	min.
23	11	27		

9. Birthplace: Baltimore Co., Md. (Town, county, and state)

10. Usual Occupation: Supervisor Cable Worker

11. Industry or business: Clifton Conduit

FATHER
12. Name: John D. Magsamen
13. Birthplace: Baltimore Co. Md.

MOTHER
14. Maiden Name: Mamie Heinbuch
15. Birthplace: Baltimore Co., Md.

16 (a) Informant: Mrs. Wm. J. C. Magsamen
(b) Address: Golden Ring & Phila. Rds.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 19, 1948 (month) (day) (year)
(c) Cemetery or crematory: Zion Luth. Cem.
Location: Stemmers Run, Md.

18 (a) Funeral director: Lassahn Funeral Home
(b) Address: 7401 Belair Road

19 (Date rec'd by registrar) OCT 16 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1948, at 2.45 P.M.

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Compound fracture of skull
and fracture of Rt. Leg Femur

Due to

Other Conditions Traumatic

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 26/6
(a) Date of injury 10-15-48 at approx. 2.15 P. M.
(b) Where did injury occur? 1625 S. Clinton St.
(c) Did injury occur at home, on farm, in industrial place, in public place? Industrial place While at work? yes
(d) Means of injury Crushed while putting belt in shaft.

23. Signature Emil L. Ruge M.D.
Medical Examiner

Date signed October 16, 1948

VS 181

67697
ES- 123157

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92 B

Registered No. 67697

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days.
(e) Length of stay in Baltimore, (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Ward St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Thomas Dixon
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-01-8718

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) May 27, 1897

8. AGE: Years	Months	Days	If less than one day
51	4	12	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Deceased Thomas Dixon
13. Birthplace ? Balto. Md.

MOTHER
14. Maiden Name Deceased Lurania Williams
15. Birthplace Balto. Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) (Burial, cremation, or removal) (b) Date thereof 10/16/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Baltimore Md.

18 (a) Funeral director Walter O. Briggs
(b) Address 1316 Hamburg St.

19 (a) OCT 16 1948 (Date received by registrar) (b) Washington Millicans, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9- 1948, at 5:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1948, to 10-9 1948 and that I last saw him alive on 10-9 1948

Immediate cause of death: Pulmonary edema — Duration
Due to: Mitral stenosis
Due to: Rheumatic Heart Disease.
Other Conditions: Ulcerated liver
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Kirkin, M.D.
Address Balto City Hosp Date signed 9 Oct 48

VS 150

67698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. 67698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 734 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 734 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Rebecca Spriggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1870

8. AGE: Years 78 | Months 7 | Days 16 | If less than one day: hr. min.

9. Birthplace Calvert Co., Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mr. Jesse Spriggs
(b) Address 734 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-48 (month) (day) (year)
(c) Cemetery or crematory Brooks Chapel
Location Mutual-Calvert Co. Md.

18 (a) Funeral director Mrs. Thomas A. Hensley
(b) Address 578 W. Biddle St.

19 OCT 16 1948 Date filed by registrar Huntington Williams, Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH October 13 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 19 48 to Oct 1 19 48, and that I last saw him alive on Oct 1 19 48.

Immediate cause of death Cardiac Arrest

Due to Hypertension

Due to Hypertension

Other Conditions Senile Atrophy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. T. Gorter M. D.

Address 1521 Eutaw Pl. Date signed 10-14-48

VS 150

G67699

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 20E

G67699 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 FOSTER AVE
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME LAWRENCE HEIMBACH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	WIDOWER

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 16, 1896

8. AGE: Years	Months	Days	If less than one day
52	5	27	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation UNEMPLOYED.

11. Industry or business

FATHER 12. Name Conrad Heimbach
13. Birthplace Germany

MOTHER 14. Maiden Name Mary Muth
15. Birthplace Germany

16 (a) Informant Andrew C. Heimbach, brother
(b) Address 3503 Foster Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lilly & Zeiler, Inc,
(b) Address 403 S. Wolfe Street.

19 (a) OCT 16 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1948 at 9:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from October 13, 1948 to October 14, 48 and that I last saw him alive on October 14, 1948.

Immediate cause of death: Respiratory Failure — Duration

Due to Syphiletic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Frank W. Baker, Jr. M. D.
Address St. Joseph's Hospital Date signed 10-14-48

VS 150

G67700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. 167700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1331 W. 40th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 W. 40th Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth O. Damm

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John W. Damm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 19, 1858

8. AGE: Years	Months	Days	If less than one day
90	1	26	hr. min.

9. Birthplace Harpers Ferry, W. Va.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Conrad Ault
13. Birthplace West Virginia

MOTHER
14. Maiden Name Annie Bosel
15 Birthplace West Virginia

16 (a) Informant Mrs. Alva Hunt
(b) Address 1331 W. 40th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

(a) OCT 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH October 15, 1948 at 8.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 Oct 15 1948 and that I last saw h CV alive on Oct 15 1948.

Immediate cause of death
Arteriosclerotic CVD
Decomp

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence J. Hunnicutt M. D.

Address 5711 Dalton Date signed 10-15-48

VS 150

667701

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667701 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution:
Harford Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH M. LUTZ

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife George Lutz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1864

8. AGE: Years	Months	Days	If less than one day
84	6	5	hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name --- Sommers
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. George Frank
(b) Address Hill Ave., Box 131, R.F.D. 6 Towson, Md.

17 (a) burial (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 2101 Belair Road

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16th, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1/ 1948 to 10/16 1948. and that I last saw h alive on 10/15 1948

Immediate cause of death: Arteriosclerotic cardio-vascular — Duration

Due to Renal

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold A. Groff M. D.
Address 8100 Harford Rd. Date signed 10/16/48

OCT 17 1948 Huntington Williams, M.D.

667702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667702

(927)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5200 McCormick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John D. Klein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5-2-1890

8. AGE: Years	Months	Days	If less than one day: hr.	min.
58	05	14		

9. Birthplace Balt. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER	12. Name	George Klein
	13. Birthplace	Md.
MOTHER	14. Maiden Name	Margaret Eckmeyer
	15. Birthplace	Md.

16 (a) Informant wife
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd

OCT 17 1948 (Date rec'd by registrar) (Huntington Williams) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16 1948, at 12 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9-1948, to 10-16 1948, and that I last saw him alive on 10-10-1948

	Duration
Immediate cause of death: Hypertensive encephalopathy	1 week
Due to: Hypertensive C.V. disease	5 yr
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Laham M. D.
Address Franklin Sq. Hosp Date signed 10-16-48

VS 150

HLH43 667703 BALTIMORE CITY HEALTH DEPARTMENT ✓ 667703

CERTIFICATE OF DEATH 157E

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County
(c) City or town Lexington (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #3 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 3-18-47

8. AGE: Years	Months	Days	If less than one day
1	19 6	29	..... hr. ..... min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Frank Hill Sr
13. Birthplace N.C.

MOTHER
14. Maiden Name Arlene Leonard
15. Birthplace N.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Reedis Baptist Cem
Location Lexington, N.C.

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd

19 (a) Date received by local registrar Oct 17 1948 (b) Huntington Hillcrest, M.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1948, at 4 05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1948, to 10-16 1948, and that I last saw him alive on 10-16 1948

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Congenital Heart Disease	
Due to Tetralogy of Fallot	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct 16, 1948
Major findings of operation: None
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature D.D. Coulter M.D.
Address The Johns Hopkins Hosp. Date signed Oct 16 '48

X

667704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667704 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 28 N Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Udoff

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-20-6240

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 61 | Months 2 | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Paul Udoff
(b) Address 122 Queenbury Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) Oct 21 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1948 at 1:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work
(d) Means of injury

23. Signature William J. Kelly M.D.
Medical Examiner.

Date signed Oct 15 1948

VS 181

667705

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667705 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4217 Pimlico Road
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (13)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4217 Pimlico Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Kahn

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1890

8. AGE: Years	Months	Days	If less than one day
58		9	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name	Dear
FATHER 13. Birthplace	Russia
MOTHER 14. Maiden Name	Dosser
MOTHER 15. Birthplace	Russia

16 (a) Informant Ida Kahn
(b) Address 4217 Pimlico Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place Huntington Williams, Mgr

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 17 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16-1948 at 1H M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1948 to Oct 15 1948 and that I last saw h alive on Oct 12 1948

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Hypertension C.V.D. Gilson	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris A Jino M. D
Address 118 St's 21st Date signed 10/16/48

2.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 667706

667706

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution West Balto General 6 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 E. Fulton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 68 | Months | Days | If less than one day hr. min

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Moses Binger
13. Birthplace Russia

MOTHER 14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Leno Lieberman
(b) Address 847 - to Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2106 Eutaw Place (Town) Washington Millimanville

[illegible] 17 1948 (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1948, to Oct 15 1948, and that I last saw h[illegible] alive on October 15 1948.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Cholangeitis

Due to Common duct obstruction due to cholelithiasis and tuberculosis

Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Teichman M.D.
Address West Balt Med Date signed Oct 18 1948

Reg. 126

VS 150

667707

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667707
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Bryant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Kamenetz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sol

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1880

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David Stein
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah
15. Birthplace Russia

16 (a) Informant Sol Kamenetz
(b) Address 2304 Bryant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-48 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Baltimore Ave

18 (a) Funeral director Jack Levin's Inc
(b) Address 1400 Eutaw Pl.

19 (a) (Date received by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14-1948 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/14 1948 to 10/14 1948 and that I last saw h alive on 10/14 1948.

Immediate cause of death: Acute pulmonary edema — Duration

Due to Acute Myocardial infarction

Due to Ch myocarditis

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. H. Hornstein M.D.
Address 104 E. Biddle St Date signed 10/15/48

X 10/15/48

VS 150

G67708

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 51B

G67708
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB S FRANK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/64

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Insurance
11. Industry or business

FATHER
12. Name Simon
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia
15. Birthplace Germany

16 (a) Informant Louis M. Frank
(b) Address 1007 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Belair Road

18 (a) Funeral director Fuhrman, Lewis, Inc
(b) Address 2600 Eastern Place Huntington Woods, Md

19 OCT 17 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14 1948, at 3:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5 1948 to 10-14 1948, and that I last saw him alive on 10-14 1948.

Immediate cause of death	Arteriosclerotic Heart failure	Duration
Due to	pulmonary and renal	
Due to	Pneumonia, uremia	
Due to	Carcinoma of prostate	
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. L. Weinstein M.D.
Address Sinai Hosp. Baltimore Date signed 10/14 M

VS 150

667709

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 92)

*667709
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1009 Pembridge Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Pembridge Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Saul Gardiner - FORMLY SAMUEL ALSO SAM

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1897

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Michael
13. Birthplace Poland

MOTHER 14. Maiden Name Esther
15. Birthplace Poland

16 (a) Informant Ida Gardiner
(b) Address 1009 Pembridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-48 (month) (day) (year)
(c) Cemetery or crematory Mount Montefore
Location Wash Blvd

18 (a) Funeral director Jack Levin
(b) Address 2100 Eutaw Pl.

19 (a) (b) Huntington Williams, Md

OCT 17 1948

VS 155

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1948, at 12:50 M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1947 to Oct. 16 1948, and that I last saw h in alive on Oct. 16 1948.

Immediate cause of death: Coronary thrombosis — Duration: months

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul E. Gardiner M. D.
Address 2212 South Rd Date signed 10/16/48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 66720

66720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2922 Riggs Ave.
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2922 Riggs Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Gibbs

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Magdalene B. Gibbs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1873

8. AGE: Years	Months	Days	If less than one day
74	9	25	hr. min.

9. Birthplace Port Royal, Va. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business B.& O. R.R.

FATHER
12. Name Charles E. Gibbs
13. Birthplace Port Royal, Va.

MOTHER
14. Maiden Name Mary S. Parr
15. Birthplace Va.

16 (a) Informant Magdalene L. Gibbs
(b) Address 2922 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/48. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Dole
(b) Address 1705 W. Fayette St. Baltimore, Md.

OCT 17 1948 (Date received by Registrar) Lexington Williams, M.D. Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Oct. 14, 1948 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1948 to Oct 14 1948 and that I last saw h[illegible] alive on Oct 14 1948.

Immediate cause of death Myocardial degeneration + insufficiency with Congestive failure

Due to Arteriosclerotic type heart disease with Coronar

Due to hypertrophy and Left ventricular

Other Conditions Angina Pectoris

Duration 3 months — several years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. W. Michel M. D.

Address 2901 Edmondson Ave. Date signed Oct 16 '48

VS 150

G67711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G67711 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219 S Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 219 S Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julian Borzuchowski

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Klemantyna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12/1869

8. AGE: Years 79 Months 3 Days 1 If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name Frank Borzuchowski

13. Birthplace Poland

14. Maiden Name

15. Birthplace Poland

16 (a) Informant Sophie Szylinski

(b) Address 219 S Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 18/48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Fred W. Ozarzuchowski

(b) Address 1930 Eastern Ave Baltimore, Md.

OCT 17 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1948 at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1948 to Oct. 13 1948 and that I last saw him alive on Oct. 13, 1948

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 10/11/48

Due to ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR DISEASE — Duration ???

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Krupa M. D.

Address 219 S. Chester St Date signed 10/15/48

VS 150

G67712 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 2

461217

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 dys

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town BAY VILLAGE, (If outside city or town limits, write RURAL and give town)
(d) Street No. 25720 LAKE, ROAD, (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin Ray Frazier, Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-17-31

8. AGE: Years	Months	Days	If less than one day
17	8	29	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER 12. Name Edwin R. Frazier
13. Birthplace Indiana

MOTHER 14. Maiden Name Cora Wickam
15. Birthplace Ohio

16 (a) Informant
(b) Address JONES HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct 18 1948 (month) (day) (year)
(c) ~~Cemetery~~ or crematory Green Mount Cem.
Location Balto, Md

18 (a) Funeral director Henry W. Jenkins & Sons Co
(b) Address York Rd. & Rossiter Ave

19 (a) OCT 17 1948 (Date rec'd by registrar) (b) Timonium, Baltimore Co. Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1948, at 1 00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1948 to Oct 16 1948 and that I last saw him alive on Oct 16 1948.

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Congenital Heart Disease	
Due to Streptococcic Throat Infection	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct 9, 1948
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature D.D. Cooley
Address The Johns Hopkins Hospital Date signed Oct 16 '48

VS 150

667713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

667713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Webster Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Olevia Nelsob

3 (b) If veteran, name war: None
3 (d) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Ferdinand G. Nelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9th, 1871

8. AGE: Years 77 Months 6 Days 6 If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John T. Baldwin
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Ann Byran
15. Birthplace Maryland

16 (a) Informant Mrs. Estella Wilson
(b) Address 1501 Webster St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Md.

18 (a) Funeral director Geo. L. Beyer Jr.
(b) Address 1512 Hollins St.

19 (a) Date received OCT 19 1948 Huntington Williams, M.D. (Registrar)

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948 at 7:20 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 7/31/48 to 10/15/48 and that I last saw h alive on 10/14/48 or

Immediate cause of death: Pulmonary Edema — Duration: 5 days

due to Cardiac Decompensation — 2½ mo

Due to Arteriosclerotic Cardio-Vascular Disease — 10 yrs.

Due to

Other Conditions Fracture Neck of Rt. Femur — 2½ mo.
(Include pregnancy within three months of death)

Date of operation 7/30/48 & 8/2/48

Major findings of operation: Transverse Fracture Neck of Rt. Femur

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: Bypassed
(a) Accident, suicide, or homicide Accident out & fell.
(b) Date of occurrence 7/30/48 at 8 P. M
(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Fall after fainting.

23. Signature Edward L. Reavell M. D.
Address 1213 Light St. Date signed 10/15/48

Earl L. Rogers M.D.

667714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

667714 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1205 Cookie st
(c) Hospital or institution: 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Cookie st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Kunkoski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Helen Kunkoski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20 1883

8. AGE: Years	Months	Days	If less than one day
65	-	25	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Frank Kunkoski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Poland

16 (a) Informant Mrs. Helen Kunkoski
(b) Address 1205 Cookie st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Balto County

18 (a) Funeral director John Lee Weber
(b) Address 401 S. Chester Street

19 OCT 17 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 130

20. DATE OF DEATH Oct 15 1948, at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 12 1948 to OCT. 15 1948 and that I last saw him alive on OCT. 15 1948.

Immediate cause of death CARCINOMA OF STOMACH — Duration 2/28/46

Due to

Due to

Other Conditions CARDIO-VASCULAR RENAL DISEASE — 9/12/48
(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Frank F. Ozenga M. D.
Address 209 [illegible] Date signed 10/16/48

VS 3

G67715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1243

G67715 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 S. Washington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 S. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Anuszewski (Anderson)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Joseph Anuszewski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 1899
8. AGE: Years 49 Months 6 Days 4 If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Byer
13. Birthplace Poland

MOTHER
14. Maiden Name Lena Pawlicki
15. Birthplace Poland

16 (a) Informant Joseph Anuszewski
(b) Address 515 S. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John A. Weber
(b) Address 401 E. Chester St

19 (a) 10 17 1948 (Date rec'd by registrar) (b) Huntington Matthews, M.D. Registrar

MEDICAL CERTIFICATION 1030

20. DATE OF DEATH Oct 14 1948. at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1948. to Oct 16 1948. and that I last saw her alive on Oct 16 1948.

Immediate cause of death
Hypostatic Pneumonia
Myocardial degeneration
Due to Cerebral Thrombosis

Duration
Hypo. 4 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. S. Leahy M. D.
Address 4324 Eastern Ave. Date signed 10/16/48

VS 8

MdBC-4B-22198
G67716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 16aa

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette Dayan Sts.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day 3½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6509 Old Work Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Louise Hartke

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/15/48.

8. AGE: Years	Months	Days	If less than one day
			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James V. Hartke.
13. Birthplace Elkridge, Md.

MOTHER
14. Maiden Name Ethel M. Ohler
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. James V. Hartke.
(b) Address 6509 Old Work Blvd.

17 (a) Interment (b) Date thereof 10/18/48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Augustines Cem.
Location Elkridge, Md.

18 (a) Funeral director Chas. Cooper & Son
(b) Address 908-03 Baltimore St.

OCT 19 1948 (b) Huntington Williamson, M.D.
(Date rec'd by registrar)

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1948 at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 1948. to 10/16 1948. and that I last saw her alive on 10/16 1948.

Immediate cause of death
Cerebral hemorrhage

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Bon Secours Hosp. Date signed 10/17/48

67717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67717

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1527 Montmorr Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Montmorr Ct. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Boone Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed or divorced. Married

6 (b) Name of husband or wife Addie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1883

8. AGE: Years 65 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Memphis, Tenn.
(Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Memphis, Tenn.

MOTHER
14. Maiden Name Addie Taylor
15. Birthplace Memphis, Tenn.

16 (a) Informant Mrs. Addie Boone
(b) Address 1527 Montmorr Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17, 1948 (month) (day) (year)
(c) Cemetery or crematory New Park Cem.
Location Memphis Tenn.

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1631 Druid Hill Ave.

OCT 18 1948 (Date rec'd by registrar) (b) Funeral for Williams, M.E.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16/48 19 at 1.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1948 to 10/16 1948 and that I last saw h[illegible] alive on 10/15 1948

Immediate cause of death: Hypertensive cardiovascular disease — Duration: UNK

Due to (Uremia)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature RAYNER BROWNE, M. D. M. D.
Address 1800 EAST MADISON ST. Date signed 10.17.48
BALTIMORE 5, MD.

VS 158

G7718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G67718 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 542 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHIN DOO WING (QUOCK DOO WING)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	Chinese	MARRIED

6 (b) Name of husband or wife Lucy Quock
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Abt. Mar. 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	7			

9. Birthplace China (Town, county, and state)
10. Usual Occupation Laundry
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace China

MOTHER
14. Maiden Name Unknown
15. Birthplace China

16 (a) Informant Kellow Quock (son)
(b) Address 542 N. Calvert St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Ming Yuen Cem
Location San Mateo Co. Calif.

18 (a) Funeral director Wm Cook Inc
(b) Address 1212 St Paul St

19 (a) OCT 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1948 at 2.10am

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Congestive Heart Failure

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed October 15, 1948

VS 151

7719

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 131a

Registered No. 66719

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd
(c) ~~Hospital or~~ institution: Harford Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Jeffrey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline A. Emerine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed~~, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) June 30 1871

8. AGE: Years	Months	Days	If less than one day
77	3	15	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Emerine
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Margaret Schneider
15. Birthplace Md.

16 (a) Informant Clarence Middleton
(b) Address 2584 Edmondson Ave

17 (a) Balto. (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Md.
Location

18 (a) Funeral director William Cook Inc.
(b) Address 1217 E. Baltimore St.

19 (a) OCT 18 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 14-Oct-1947 to 15-Oct-1948 and that I last saw h.er alive on 15-Oct 1948.

Immediate cause of death Cerebral Embolism — Duration 3 days

Due to Arteriosclerotic Cardio Vascular Renal Disease — Oct-47

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no) (Place)
(e) Means of injury

23. Signature Chas W Edmonds

Address 2746 Alameda Date signed 16-Oct-48 M D

VS 150

5720

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 16720

CERTIFICATE OF DEATH 55E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2126 Vine St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs, 4 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2126 Vine St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY DOLORES SEEBACH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 10 1933

8. AGE: Years 15 | Months 34 | Days 7 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Harry Seebach.
13. Birthplace Balto

MOTHER
14. Maiden Name Mary V. Schmeckes
15. Birthplace Balto.

16 (a) Informant Mrs M. D Seebach
(b) Address 2126 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery or crematory London Park.
Location Frederick Rd.

18 (a) Funeral director Wm Cookerly
(b) Address 1217 St Paul St

19 (a) 10 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1948, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1933 to Oct 17 1948, and that I last saw h[illegible] alive on Oct 17 1948.

Immediate cause of death. Bilateral pneumothorax
Secondary

Due to Mediastinal emphysema and shock

Due to Rupture of esophagus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation March 9 '48, Aug 24 '48

Major findings of operation: Mediastinitis
Carcinoma of esophagus

of autopsy:

Duration
23 Mo.
3 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed Oct 14 1948

VS 199

X

67721

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. 67721

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun St.
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (~~yrs.~~ ~~mos.~~ or days) one
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Bedford & Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella T. Dorbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
F	W	Separated

6 (b) Name of husband Michael John Dorbert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 19, 1894

8. AGE: Years	Months	Days	If less than one day
54	1	26	hr. min.

9. Birthplace Camden N.J. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name James G. Hyatt
13. Birthplace Md.

MOTHER
14. Maiden Name Priscilla Pedrick
15. Birthplace N.J.

16 (a) Informant Marie B. Schriefer
(b) Address Bedford & Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Maryland Park
Location Parkville Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 127 E. Paul St.

19 (a) 10 1948 (Date rec'd by registrar) Registrar for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948 at 6:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10/15 1948 to 10/15 1948 and that I last saw her alive on Oct 15 1948.

Immediate cause of death Peritonitis

Due to ruptured gall Bladder

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bobby L. Jones M.D.
Address Franklin Square Hosp. Date signed 10/15/48

1276

VS 150

5-722

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 164c

Registered No. 667722

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & 033 St.
(c) Hospital or institution: UNION MEMORIAL HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 HOLLEN RD. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willard E. Walters

3 (b) If veteran, name war: WORLD WAR II
3 (c) Social Security Account No. 197-05-5715

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 13 1906

8. AGE: Years	Months	Days	If less than one day
42	6	4	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation MACHINE HAND
11. Industry or business BLACK & DECKER

FATHER
12. Name HARRY R. WALTERS
13. Birthplace MARYLAND

MOTHER
14. Maiden Name DAISY SHOPPERT
15. Birthplace W. VIRGINIA

16 (a) Informant: HARRY T. WALTERS
(b) Address SPARKS MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery or crematory CEDAR GROVE
Location MT. CARMEL RD HERFORD MD.

18 (a) Funeral director Wm Oak Inc.
(b) Address 1217 St Paul St.

19 (a) OCT 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Oct. 1948 at 11 A. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ✓, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound (22 rifle) of mouth & brain

Due to

Other Conditions Despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 17 Oct. 48 at 10:20 A. M.
(b) Where did injury occur? Home
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Gunshot

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 17 Oct. 48

VS 151

X

667723 BC 48 21157 667723
235231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 84a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Charles,
(c) City or town Port Tobacco,
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby "~~Margaret~~" Compton (Harriet Elizabeth)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1 - 1948

8. AGE: Years	Months	Days	If less than one day
female 0	0	17 h	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Colvin Compton
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Wade
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/48 (month) (day) (year)

(c) Cemetery or crematory
Location La Plata, Md.

18 (a) Funeral director Hunter & Bryan
(b) Address Waldorf, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 17 - 1948 at 3 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 1948 to 10-17- 1948 and that I last saw her alive on 10-17- 1948.

Immediate cause of death Atelectasis — Duration

Due to

Due to

Other Conditions Congenital anomaly - Mongolism
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George W. Corner, Jr. M. D.
Address Johns Hopkins Hospital Date signed 10-17-48

VS 150

161a

667724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 516

667724 ✓ Registered No.

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 206 Oakdale Road
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State "c." (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Oakdale Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Van Vert Klinefelter, Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ella Klinefelter
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) December 17, 1875

8. AGE: Years	Months	Days	If less than one day
72	9	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Proprietor, printing
11. Industry or business business

FATHER
12. Name Van Vert Klinefelter
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah Hooper
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ella Klinefelter
(b) Address 206 Oakdale Road

17 (a) Burial (b) Date thereof 10/18/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~crematory~~ Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director John L. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place, Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1948, at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1948, to Oct 15 1948, and that I last saw him alive on Oct 15 1948.

Immediate cause of death	Duration
Carcinoma of Prostate	1 year
Due to Nephritis interstitial chronic	2 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hulbert F. Stillman M. D.
Address 6 E. Biddle St. Date signed

VS 150

X

G67725 CERTIFICATE CORRECTED 9-1-50 G67725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 12B

LCH 123591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 538 W. Mulberry Street 1 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSALEE WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/8/23

8. AGE: Years	Months	Days	If less than one day
25	1	5	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dennis Williams
13. Birthplace N.C.

MOTHER
14. Maiden Name Louisa Harry
15. Birthplace N.C.

16 (a) Informant Records of Balto. City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 18, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13/48 19 , at 9:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8 1948 to 10-13 1948.
and that I last saw alive on 10-13 1948.

Immediate cause of death Pul embolism ? Duration
Pul tbc

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. T. Nelson M. D.
Address Date signed 10-14-48

VS 150

667726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667726 Registered No. 46

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts. 12-5
(c) Hospital or institution: Mercy Hospital, Balto
(d) Length of stay in Hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 E. Federal St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LUVENIA PATCHER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: William Patcher
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr): Aug 1, 1890
8. AGE: Years 58. Months 7 Days 8 If less than one day hr. min.
9. Birthplace: Birmingham Alabama (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: Marion McGaw
13. Birthplace: Alabama

MOTHER
14. Maiden Name: Parsy Mason
15. Birthplace: Alabama.

16 (a) Informant: Nonsey Dadaw
(b) Address: 937 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 18, 1948 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location

18 (a) Funeral director: Mrs Kate R. Williams
(b) Address: 322 N. Schroeder St.

19 (a) OCT 8 1948 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948 at 5:35AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1948 to Oct 15 1948 and that I last saw her alive on Oct 15 1948.

Immediate cause of death: Post operative shock — Duration: 8 hrs.

Due to: Rupture of duodenal stump

Due to: Whipple Procedure

Other Conditions: Ca head & pancreas — Duration: ?
(Include pregnancy within 3 months of death)

Date of operation: Oct 13, 1948.

Major findings of operation: Ca head & pancreas

of autopsy: Confirmatory, above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: R. M. Emmert M. D.
Address: Mercy Hosp. Date signed 10/15/48.

VS 150

66772?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ 66772?

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1502 Harlem Ave
(c) Hospital or institution: .....
16
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Harlem Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME William Henry Douglas

3 (b) If veteran, name war: | **3 (c) Social Security Account No.** .....

4. Sex M | **5. Color or race** C | **6 (a) Single, married, widowed, or divorced.** Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 1896

8. AGE | Years 52 | Months 7 | Days | If less than one day ..... hr. ..... min.
~~11~~ (d) (m)

9. Birthplace Calvert County, Maryland (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business .....

FATHER
12. Name Lemuel Douglas
13. Birthplace Calvert County, Maryland

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Calvert County, Maryland

16 (a) Informant: Mrs. Hattie Douglas.
(b) Address 2001 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** October 19 1948. (month) (day) (year)
(c) Cemetery or crematory Int. Auburn.
Location .....

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Edmondson Ave.

19 (a) ..... (Date rec'd by registrar) ..... Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1948 at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C V Disease
Due to .....
.....
Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? ..... While at work?
(d) Means of injury .....

23. Signature J. P. Sullivan M.D.
Medical Examiner.
Date signed 10/13/48

067728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

067728 Registered No. 37c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 W. Hamburg Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: HOWARD BOONE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): November 23, 1904

8. AGE: Years: 43 | Months: 10 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Enfield, North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: George McWilliams
13. Birthplace: Enfield, North Carolina

MOTHER
14. Maiden Name: Jessie Boone
15. Birthplace: Enfield, North Carolina

16 (a) Informant: Jessie Fennell.
(b) Address: 313 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 18, 1948 (month) (day) (year)
(c) Cemetery or crematory: Mt. Zion
Location

18 (a) Funeral director: Mrs Katie R Williams
(b) Address: 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Interred by Williams M

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14 19 48, at 10:15 M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Epidemic Encephalitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature: Earl L Royer M.D.
Medical Examiner.
Date signed 10-15-48

VS 151

G67729 ✓ G67729

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. .....

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3214 Elliott St
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3214 Elliott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country .....

3 (a) FULL NAME Stefan Potyraj

3 (b) If veteran, name war /

3 (c) Social Security Account No. /

4. Sex Male

5. Color or race white

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nora Potyraj

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Aug 11 1886

8. AGE: Years 62 | Months 2 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business Balto Copper Works

FATHER
12. Name Stefan Potyraj
13. Birthplace Poland

MOTHER
14. Maiden Name Marya Lemiko
15. Birthplace Poland

16 (a) Informant Nora Potyraj
(b) Address 3214 Elliott St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Oct 19 1948 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cemetery
Location Dundalk Ave

18 (a) Funeral director John J Duda
(b) Address 2849 Hudson St.

19 (a) OCT 18 1948 (Date rec'd by registrar) **(b)** Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 19 48 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 19 48 to Oct. 16 19 48, and that I last saw h/m alive on Oct. 14 19 48.

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 6 hrs.

Due to ARTERIOSCLEROSIS — 2 yrs.

Due to .....

Other Conditions HEMIPLEGIA — 1 yr.

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....

23. Signature Benjamin Schreiber M. D.
Address 121 S. Hanover St. Date signed 10/14/48

VS 150

X

Coffee approved

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 6627 (30)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 0
(c) Hospital or institution: WEST BALTIMORE GENERAL
(d) Length of stay in hospital or inst. (~~year~~ days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 45 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County .....
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2543 LAURETTA AVE. (If rural give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country ITALY

3 (a) FULL NAME ~~Daniel~~ DONATO MACCIOLA
3 (b) If veteran, name war No
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife LEONDINA
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JULY-4-1882

8. AGE: Years	Months	Days	If less than one day
66	3	13	..... hr. ..... min.

9. Birthplace LARINO ITALY (Town, county, and state)
10. Usual Occupation TAILOR
11. Industry or business TAILORING

FATHER
12. Name VINCENT MACCIOLA
13. Birthplace LARINO, ITALY

MOTHER
14. Maiden Name CONCETTA CORVENELLA
15. Birthplace LARINO ITALY

16 (a) Informant ROSE M. STRAUSSER
(b) Address 2543 LAURETTA AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-20-48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location .....

18 (a) Funeral director Raymond C. Sink
(b) Address 3603 Belair Road

19 (a) ..... (To be supp'd by registrar) (b) ..... Registration District No.

OCT 18 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1948 at 1:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1948 to Oct 17 1948. and that I last saw h[illegible] alive on Oct 17 1948.

Immediate cause of death	Duration
Cardio-respiratory arrest	
Due to Cerebral hemorrhage	
Due to Hypertensive cerebral vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury

23. Signature Howard Sinker M.D.
Address West Baltimore Date signed Oct 18 1948

Heal Dong

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 251

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1536 Light Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 3m
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1536 Light Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH M. FISCHBECK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Christian W. Fischbeck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/1886

8. AGE: Years	Months	Days	If less than one day
62	0	24	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob Sippel
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara E. Fleck
15. Birthplace Germany

16 (a) Informant Family
(b) Address Same

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Avenue

18 (a) Funeral director James L. McCauley
(b) Address 130 East Fort Avenue

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

OCT 19 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15-48 19 , at 7a. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to 10-14 1948 and that I last saw h[illegible] alive on 10-14 1948

Immediate cause of death	Duration
Coronary Thrombosis	
Due to arteriosclerosis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James McGrath
Address 1E. Randall St. Date signed 10/16/48 M.

W&S 190

67732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67732

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1527 NORTHEATE RD. (18)
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 5301 N. 13th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME JOHN G. JOSBERGER

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	White	Widowed

6 (b) Name of husband or wife Caroline Josberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 17-1865

8. AGE: Years	Months	Days	If less than one day hr.	min.
82	10	—		

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation (Helper in department store
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace "

MOTHER
14. Maiden Name Not Known
15. Birthplace "

16 (a) Informant MRS. MARIE NEWELL
(b) Address 1527 NORTHEATE RD.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-18-48 (month) (day) (year)
(c) Cemetery or crematory Welte Funeral Home
Location Philadelphia, Pa.

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto 31.

19 (a) (Date rec'd by registrar) (b) Entered by Attendant

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1948 at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1948 to 10/17 1948.
and that I last saw him alive on 10/16 1948.

Immediate cause of death CEREBRAL THROMBOSIS — Duration 6 weeks

Due to CEREBRAL ARTERIOSCLEROSIS —

Due to

Other Conditions SENILITY
GENERAL ARTERIOSCLEROSIS
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 6330 Belair Rd (6) Date signed 10/17/48

VS 1R 1948

67733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 667733

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 E Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Cassidy

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Michael Cassidy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 6, 1865

8. AGE: Years: 83 | Months: 8 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: House Wife

11. Industry or business

FATHER
12. Name: Samuel Gallagher
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Jane
15. Birthplace: Ireland

16 (a) Informant: Mrs. Mary McCabe
(b) Address: 815 E Chase St.

17 (a) Baltimore (Burial, cremation, or removal) (b) Date thereof Oct 20 1940 (month) (day) (year)
(c) Cemetery or crematory: Mt. Cathedral
Location: 4300 Old Frederick Rd

18 (a) Funeral director: Edwyn W. Conklin
(b) Address: 924 E. Eager St.

19 (a) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1940, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1940 to Oct. 17, 1940 and that I last saw her alive on Oct. 16 1940.

Immediate cause of death: Coronary Thrombosis — Duration

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Vroom Wm

Address 1623 E. N. Ave. Date signed Oct 17 1940 M. D.

V S 150

G677.34

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G677.34

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 Hamilton Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 825 Hamilton Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARA SIMPSON

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	no	female	white	single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 76			hr. min.

9. Birthplace Coole, Ireland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Samuel Simpson
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ann Woodsale
15. Birthplace Ireland

16 (a) Informant Miss Annie Simpson
(b) Address 825 Hamilton Terrace

17 (a) Burial (b) Date thereof 10/18/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1948, at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1948 to Oct. 15 1948
and that I last saw h alive on Oct. 11 1948

Immediate cause of death: Acute Dilatation of Heart — Duration 6

Due to: Hypertensive Cardio-Vascular Disease

Other Conditions: Old Age
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. G. Mayer M. D.
Address 516 Cathedral St. Date signed 10-16-48

V3 150

677735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

✓ 677735 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkens ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 Chilham Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah A. Burke.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	white	widow

6 (b) Name of husband or wife George A. Burke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 3, 1869

8. AGE: Years	Months	Days	If less than one day
79	2	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George R. Skillman
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Elizabeth Pearce
15. Birthplace Md

16 (a) Informant Mrs. Anna Becker
(b) Address Same.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory St. Paul's Lu. Cem.
Location Arcadia, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 16 1948 at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10/48 19 to 10/16 19 48 and that I last saw her alive on 10/16 1948.

Immediate cause of death
Resp failure
Due to Cachexia
Due to Ca. of the Colon
Resection - Carcinoma
Other Conditions Fecal fistula

(Include pregnancy within 3 months of death)
Date of operation Sept 32, Oct 4.
Major findings of operation: Ca. of the Colon - Recurrent
of autopsy Diverticula

Duration 36 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Lowe M.D.
Address St Agnes Hosp Date signed 10/14/48

VS 150

6727.56

BALTIMORE CITY HEALTH DEPARTMENT ✓ 6627.56

CERTIFICATE OF DEATH 50

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2127 W. Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLINE L. HERTLEIN

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Apr. 12, 1863

8. AGE: Years 85 | Months 6 | Days 2 | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: —

11. Industry or business

FATHER
12. Name: Gotfred Hertlein
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna Sommers
15. Birthplace: Germany

16 (a) Informant: Miss Phyllis Hertlein
(b) Address: 2127 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Oct. 18, 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1948, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1, 1948 to 10/14 1948 and that I last saw h[illegible] alive on 10/14 1948

Immediate cause of death: Carcinoma of Breast with Metastasis to Lungs — Duration: 1 year

Due to

Due to

Other Conditions: Myocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. W. Carlin M. D.
Address 2145 W Balto St. Date signed 10/15/48

VS 150

77737

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 92a

Registered No. 6627

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Park Ave.
(c) Hospital or institution: Wellesley Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 Taplow Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA LEE WILSUR

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced widow

6 (b) Name of husband or wife Albert Wilbur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 11, 1877

8. AGE: Years 71 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George W. Quarles
13. Birthplace Va.

MOTHER
14. Maiden Name Martha J. Evans
15 Birthplace Va.

16 (a) Informant Mrs. Newton Kidd
(b) Address 122 Taplow Rd.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Oct. 18, '48 (Date rec'd by registrar) **(b)** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1948, at 2:25p M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948, to Oct 15 1948, and that I last saw h[illegible] alive on Oct 15 1948.

Immediate cause of death Coronary Thrombosis — Duration 1 hr.
Due to Cerebral Hemorrhage — Duration 3 mos.
Due to Arterial Sclerosis — Duration 5 yrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2508 Garrison Blvd Date signed 10/16/48

VS 150

677.38

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 677.38

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3165 Keswick Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3165 Keswick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELLEN KILPATRICK

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Thomas Henry Kilpatrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 25, 1874

8. AGE: Years	Months	Days	If less than one day
74	2	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Worsdell
13. Birthplace England

MOTHER
14. Maiden Name Mary Ann Dix
15 Birthplace Baltimore

16 (a) Informant Miss Helen E. Kilpatrick
(b) Address 3165 Keswick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Oct. 16 (Date rec'd by registrar) (b) Hunting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1948, at 10:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1948 to Oct 15 1948, and that I last saw her alive on Oct 15 1948.

Immediate cause of death Arteriosclerotic CVD Decomp
Due to Remedyed Carcinomatosis
Due to Ca of Breast

Duration
?
3 mo

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Linnane M. D.
Address 3711 Dallas Rd Date signed Oct 16 48

VS 150

6627.39

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 178a

6627.39 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 844 Mangold St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THEODORE J. SCHORBACH

3 (b) If veteran, name war None

3 (c) Social Security Account No. 212-09-8871

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	MARRIED

6 (b) Name of husband or wife Margaret A. Schorbach
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) July 14, 1895

8. AGE: Years	Months	Days	If less than one day
53	3	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Foundry Worker
11. Industry or business Piston Ring Co.

FATHER
12. Name "illiam Schorbach
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Katherine ?
15. Birthplace Baltimore, Md.

16 (a) Informant Margaret A. Schorbach
(b) Address 844 Mangold St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Balto md
Location
18 (a) Funeral director Jos B. M. Walter
(b) Address Balto, Md.

19 10/18/48 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1948 at 9.30a M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquir V hereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to
Inhalation of Gas
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following: 21/
(a) Date of injury 10-16-48 at approx. 9.00 a. M.
(b) Where did injury occur? 844 Mangold St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Gas heater on but unlit

23. Signature Emil Rogge M.D. (Medical Examiner)
Date signed October 16, 1948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 16750

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2437 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Dora S. Pines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband David Pines

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25 1893

8. AGE: Years 54 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Saleslady

11. Industry or business Merchandise - Retail

FATHER
12. Name Isaac Singer
13. Birthplace Unknown

MOTHER
14. Maiden Name ? Sussman
15. Birthplace Unknown

16 (a) Informant Mr. David Pines
(b) Address 2437 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto., Md.

18 (a) Funeral director David Sondheimer & Son
(b) Address 1902 Eutaw Place

19 (a) 10/19/48 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17-1948, at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12 1948 to 10-17 1948, and that I last saw her alive on 10-17 1948.

Immediate cause of death Coronary occlusion — Duration

Due to Arteriosclerotic heart disease

Due to Coronary occlusion; hypertensive heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Judith Landau M. D.
Address Sinai Hospital Date signed 10-17

VS 150

X

7741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 16777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1552 Carswell Pl
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1552 Carswell Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Rebhan
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry Rebhan
6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24 - 1880

8. AGE: Years	Months	Days	If less than one day
68	1	20	hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name John Stetler
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Rebhan
(b) Address 1552 Carswell Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-48 (month) (day) (year)
(c) Cemetery or crematory Balto Cem.
Location North Ave. & Milly Ln

18 (a) Funeral director John E. Oliver Sons
(b) Address 2435 E Oliver Pl

19 10/18/48 (b) Registrar Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 14 - 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1947 to Oct 14 1948 and that I last saw her alive on Oct 14 1948.

Immediate cause of death Cardiac decompensation — Duration

Due to Generalized Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Jack T. Singer
Address 5062 Roberts Date signed 10 15 48

VS 150

667742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462

Registered No. 667742

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Mos. 7 days.

(e) Length of stay in Baltimore (yrs., mos., or days) (2)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1421 McCulloh St. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Edith M. Hayson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Spencer M. Hayson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1881

8. AGE: Years	Months	Days	If less than one day: hr.	min.
67	4	4		

9. Birthplace Virginia Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER

12. Name Orlando Brown

13. Birthplace Maryland

MOTHER

14. Maiden Name Harriett Ware

15. Birthplace Virginia

16 (a) Informant Hattie Douglas

(b) Address 1000 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore Md.

18 (a) Funeral director Mrs. James C. Hensley

(b) Address 57 E. Biddle St.

19 (a) Oct. 19 (Date rec'd by registrar) (b) Henderson Wilson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1948, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 9 1948, to Oct. 15 1948 and that I last saw her alive on Oct. 15 1948

Immediate cause of death Cancer Stomach — Duration 2 mos.

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 3/15/48

Major findings of operation: Ca Stomach

of autopsy: Ca Stomach

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify)

(e) Means of injury

23. Signature Robert E. Lucas

Address Mercy Hosp. Date signed 10/16/48

VS 150

67743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67743

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2515 Foster Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2515 Foster ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Stacharowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-0301

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1872

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76	3	25		

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph Stacharowski
13. Birthplace Poland

MOTHER
14. Maiden Name Michalena Pilachowski
15. Birthplace Poland.

16 (a) Informant Mrs. Mary Stacharowski
(b) Address 2515 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-48 (month) (day) (year)
(c) Cemetery St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) OCT 20, 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17th 1948, at 7:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1948 to Oct. 17 1948, and that I last saw h[illegible] alive on 10/17 1948

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	10/15/48
Due to ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR DISEASE	5/4/48
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(e) Means of injury

23. Signature Joseph F. Ahearn M. D.
Address 209 [illegible] Date signed 10/18/48

VS 150

7744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

✓ G67744 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 N. Maderia St.,
(c) Hospital or institution: 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Maderia St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK ADAM HEISE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances Heise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1901

8. AGE: Years	Months	Days	If less than one day
47	3	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Rent collector
11. Industry or business

FATHER
12. Name John C. Heise
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Schelpper
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Frances Heise
(b) Address 222 N. Maderia St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 18/48 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Balto Md

18 (a) Funeral director Wilhide Funeral Home
(b) Address 2008 Orleans St.

19 OCT 18 1948 (Date rec'd by registrar) (b) Trentington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1948 at 1:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29-48 19 . to 10-14- 19 48, and that I last saw h alive on 10-14- 19 48.

Immediate cause of death	Duration
Chronic Myocardial Disease	1 year
Due to Portal Cirrhosis	2 years
Due to Chronic Alcoholism	10 year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. B. Moore, M.D. M. D.
Address 448 W. Lexington Ave Date signed 10-15-48

VS 150

27745

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

162 B

Registered No. 16772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4901 Hutton Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4901 Hutton Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude G. Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ---

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 4, 1877

8. AGE: Years	Months	Days	If less than one day
71	3	11 d	hr. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John H. Gordon
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ruth L. Stinchcomb
15. Birthplace Baltimore Co., Md.

16 (a) Informant Mrs. E. L. Hoddinott
(b) Address 2646 W. North Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) [illegible] (Signature of local registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

11.30

20. DATE OF DEATH October 14, 1948 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1948 to 10/14 1948, and that I last saw h[illegible] alive on 10/14 1948

Immediate cause of death Cardiac Failure — Duration 2 days

Due to Senility

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Haeun M. D.
Address (44) W. North Ave Date signed 10/15/48

VS 150

Keep this space free for typewriting; if typewriter is not available, please write the causes of death clearly and legibly.

67746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No. 66776

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Dukeland St.
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard J. McGarity

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine S. McGarity
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 2, 1905

8. AGE: Years	Months	Days	If less than one day
43	6	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Substitute Mail Carrier
11. Industry or business

FATHER
12. Name Bernard J. McGarity
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret O'Brien
15. Birthplace Md.

16 (a) Informant Mrs. Catherine S. McGarity
(b) Address 2222 Poplar Grove St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director E. Howard Strong
(b) Address 3207 W. North Ave.,

19 (Date rec'd by registrar) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16 1948, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1948 to 10-16 1948 and that I last saw him alive on 10-16 1948

Immediate cause of death: Acute Coronary Occlusion — Duration

Due to

Due to

Other Conditions Pre-pyloric gastric ulcer (malignancy (?))
(Include pregnancy within 3 months of death)

Date of operation 10-16-48

Major findings of operation: chronic perforated

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. W. Bineman M.D.
M. D.
Address WBGH Date signed 10-16-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 667247

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3714 Ferndale Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57-3-6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3714 Ferndale Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elmer W. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma M. Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1891

8. AGE: Years 57 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Electrical Contractor

11. Industry or business

FATHER
12. Name Edward Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. Emma M. Thomas
(b) Address 3714 Ferndale Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) 10/18/48 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16th 1948, at 7:10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. N. Kemmerer M.D. Medical Examiner.

Date signed Oct 16, 1948

Registrar

VS 151

667748 3C-48-22605

667748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) [redacted]
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 4108 Marx Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Boy McCrory "B"

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | **5. Color or race** White | **6 (a) Single, married, widowed, or divorced.**

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 17 1948

8. AGE: Years | Months | Days | If less than one day 7 hr. 43 min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name Donald Joseph McCrory
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Catherine Elizabeth Sheehy
15. Birthplace Baltimore Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct. 18, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd
18 (a) Funeral director Edwin W. Conklin
(b) Address 924 E. Lexington St. Baltimore, Md.

19 (a) OCT 18 1948 (b) .....
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1948, at 8 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1948 to Oct 17 1948 and that I last saw h[redacted] alive on Oct 17 1948.

Immediate cause of death — **Duration**

Prematurity

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Eugene O. Goldstein M. D.
Address J. H. Hospital Date signed 10/17

VS 150

Please make the entries on death clearly and legibly.

G67749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G67749 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave.
(c) Hospital or institution:
Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16½ days
(e) Length of stay in Baltimore (yrs., mos., or days) Whole life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Auchentoroly Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary A. Costello

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single.

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-22-78

8. AGE: Years	Months	Days	If less than one day
70	0	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation House work
11. Industry or business at home

FATHER
12. Name John F. Costello
13. Birthplace County Kerry, Ireland

MOTHER
14. Maiden Name Mary Jane McGovern
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ella Browning
(b) Address 4900 Old Frederick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Cowan & Son
(b) Address 900-03 Hollins St.

19 (a) OCT 18 1948 (b) Williams, Md
(Registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16th 1948, at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1948 to 10-16 1948, and that I last saw her alive on 10-15 1948.

Immediate cause of death	Duration
Cardiac Rafl failure	
Due to Hypertension Arteriosclerosis Cardio-Vasc. Dis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Chas. L. Carr Jr M.D.
Address St Agnes Hosp - Date signed 10/16/48

VS 159

67750 Gunstall Johnson ✓ 67750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67750

1219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2615 Boone St
(c) Hospital or institution: 4-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Boone St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Gunstall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Married

6 (b) Name of husband or wife Mary Gunstall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1881

8. AGE: Years	Months	Days	If less than one day
67	5	-	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Benjamin Gunstall
13. Birthplace Va

MOTHER
14. Maiden Name Mary P.
15. Birthplace Va

16 (a) Informant Drusella Gunstall
(b) Address 2615 Boone St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 19-48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location Baltimore

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St Baltimore, Md

19 (a) OCT 18 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948, at 11 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948 to Oct 15 1948, and that I last saw h alive on Oct 15 1948

Immediate cause of death Cardio. Renal Disease — Duration 14 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? Park (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Frank A Johnson M.D.
Address 2029 Guilford Ave Date signed Oct 17 1948

V S 150

Keep this certificate clear. Physicians: please write the causes of death clearly and legibly.

6677-51 Accident room

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 921

6677-51 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 E. Monument st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel Barney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar-4-1900

8. AGE: Years 48 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Randolph Blackwell
13. Birthplace md

MOTHER 14. Maiden Name Martha Jackson
15. Birthplace md

16 (a) Informant Thelma Barney
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Rest
Location Towson md

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) OCT 18 1948 (Date rec'd by registrar) Registrar

VS 150 To be approved by Medical Ex

MEDICAL CERTIFICATION

05p

20. DATE OF DEATH Oct. 14 1948, at 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1948 to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death: Cardiac Failure — Duration

Due to: Hypertensive Cardiovascular Disease

Other Conditions

(Include pregnancy within three months of death)

Date of operation

Major findings of operation

of autopsy:

CERTIFICATION APPROVED BY PHYSICIAN
CHIEF OR ASST. MEDICAL EXAMINER

25 1

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify home, farm, etc.)
(e) Means of injury

23. Signature Thomas J. P. Johns

Address Johns Hopkins Hosp (Date signed) 10/15/48

×

G67752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67752

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 18 days
(e) Length of stay in Baltimore (yrs., mos., or days): 18 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Va. (b) County:
(c) City or town: Arlington (If outside city or town limits, write RURAL and give town)
(d) Street No.: 3908 N. 5th St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country:

3 (a) FULL NAME: ROGER CHARLES COOPER

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Va. Cooper
6 (c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): May 21, 1912

8. AGE: Years 36 | Months 4 | Days 26 | If less than one day: hr. min.

9. Birthplace: New York (Town, county, and state)
10. Usual Occupation: Adm. Asst.
11. Industry or business: U.S. Public Health Service

FATHER
12. Name: Charles Cooper
13. Birthplace: NJ

MOTHER
14. Maiden Name: May Agnes Baker
15 Birthplace: NJ

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: Oct 18 1948 (month) (day) (year)
(c) Cemetery or crematory:
Location: Arlington, Va.

18 (a) Funeral director: Harry Fultz & Co.
(b) Address: 401 Edmondson Ave

19 OCT 18 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17 1948, at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29 1948, to Oct. 17 1948, and that I last saw him alive on Oct. 17 1948.

Immediate cause of death: Leukemia, myelogenous, chronic — Duration: 1 yr.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon
Address: Clinical Director Date signed: 10/18/48 M.D.

V S 130

6677:87 9989

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52a

Registered No. 6677:53

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - (If outside city or town limits, write RURAL, and give town)
(d) Street No. 625 S. Ponca St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marko Benkovic

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Barbara -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 9-25-86
8. AGE: Years 63 | Months - | Days 22 | If less than one day hr. min.

9. Birthplace Yugoslavia - (Town, county, and state)
10. Usual Occupation Crane Operator -
11. Industry or business

FATHER
12. Name Judge Benkovic -
13. Birthplace Yugoslavia -

MOTHER
14. Maiden Name Helen
15. Birthplace Yugoslavia

16 (a) Informant Mercedes -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Cerna Hill Rd

18 (a) Funeral director Lilly & Zeller
(b) Address 903 S. Wolfe St.

19 OCT 18 1948 (Date rec'd by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

11.05

20. DATE OF DEATH Oct. 17 1948 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1948 to Oct 17 1948 and that I last saw h alive on Oct 17 1948

Immediate cause of death Lymphosarcoma
Contributing to lungs
Due to some
Due to
Other Conditions pleural effusion
(Include pregnancy within 3 months of death)

Duration: 2 yrs / 5 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work? Specify)
(e) Means of injury

23. Signature H E Beckmann M D
Address Johns Hopkins Hosp Date signed

VS 150

77:54

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 66777:4

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 842 S. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME emc JAMES Edgar ARNOLD

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-7660

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Francis Viola

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1879

8. AGE: Years	Months	Days	If less than one day
69	4	20	hr. min.

(cjm)

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Edgar F. Arnold
13. Birthplace Maryland

MOTHER
14. Maiden Name Florence A. Bourek
15. Birthplace Maryland

16 (a) Informant Martha Brammer
(b) Address 5604 Benton Heights Avenue

17 (a) Burial (b) Date thereof 10/ 18/ 48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Frederick Avenue

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe Street.

19 (a) OCT 18 19[illegible] Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1948, at 7:05 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
A S C V D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. L. Ryan M.D.
Medical Examiner.

Date signed 10-15-48

VS 181

6677:55

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 6677:55

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 - Dennison St
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 - Madison ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Hicks

3 (b) If veteran, name war: | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	widowed

6 (b) Name of husband or wife Dead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-16-1889

8. AGE: Years	Months	Days	If less than one day
58	10	29	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Mr Jack Bryant
13. Birthplace North Carolina

MOTHER
14. Maiden Name Miss Mary Porter
15. Birthplace North Carolina

16 (a) Informant Mr Thomas Hicks
(b) Address 2 6 0 Robert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18, 1948 (Month) (Day) (Year)
(c) Cemetery or crematory Family Lot
Location Odenton, Md Anne Arundel Co

18 (a) Funeral director Mr. George W. Hollan
(b) Address 1631 Druid Hill Ave.

19 (a) [redacted] (Date received by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15/1948 at 5:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1948 to Oct 15 1948, and that I last saw h[illegible] alive on 15 Oct 1948.

Immediate cause of death	Duration
Cardio Vascular Accident	
Due to Diabetes Mellitus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address [illegible] Date signed 10-15-48

VS 180

6677.56

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

Registered No. 6677.56

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Caldwell St.
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 Hudson St (If rural give location)
(e) Citizen of foreign country? Yes or (No)
If yes, name country

3 (a) FULL NAME Nelson D. Grove

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Rachel C. Grove
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 15 1889

8. AGE: Years	Months	Days	If less than one day
59	4	—	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Clerk, Retired

11. Industry or business Railway Express Agency

FATHER	12. Name ?
	13. Birthplace ?
MOTHER	14. Maiden Name ?
	15. Birthplace ?

16 (a) Informant Charles W. Grove
(b) Address 6324 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18 1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Windsor Mill Rd.

18 (a) Funeral director Paul C. Ebenowitz
(b) Address 2615-17 Wheatsheaf Ave.

19 (a) OCT 18 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948, at 2:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from January 1948 to October 15 1948, and that I last saw him alive on Oct 15 1948

Immediate cause of death Gastric and Esophageal hemorrhage — Duration

Due to Cirrhosis of Liver

Due to Chronic Congestive Heart Failure

Other Conditions Arteriosclerosis generalized (Including pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bobby F. Jones
Address Franklin Square Hosp. Date signed 10/15/48 M D

VS 150

6777.57 122993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

6677.57 Registered No.

1. PLACE OF DEATH:
(a) Baltimnre City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md, (b) County Baltimore,
(c) City or town Raspburg. (If outside city or town limits, write RURAL and give town)
(d) Street No. 7404 Brookwood, Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Bankard Jr. (WILLIAM JOHN BANKARD, JR.)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-09-0323

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Laura Bankard
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) 7-4-10

8. AGE: Years	Months	Days	If less than one day: hr.	min.
38	3	13		

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Standard Oil Company

FATHER
12. Name William Bankard
13. Birthplace Md.

MOTHER
14. Maiden Name Hazel Lee Johnson
15. Birthplace Maryland

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 OCT 18 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 17 - 1948 at 1:26 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15-1948 to 10-17-1948. and that I last saw him alive on 10-17-1948.

Immediate cause of death Hepatic coma — Duration

Due to Cholelithiasis & ch. cholecystitis & pancreatic cysts & ch. pancreatitis

Other Conditions Subarachnoid hemorrhage, Diabetes mellitus, pericarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Of autopsy: Fibrinous pericarditis, enlarged liver, scarring of head of pancreas

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury (Specify)

23. Signature [illegible]
Address Dr. J. H. H. Date signed 10/21/48

VS 150

126

6677 Geyer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6677

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Bayonne Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 77-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Bayonne Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Joseph Kosker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1879

8. AGE: Years 68 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation salesman

11. Industry or business Levering Coffee Co.

FATHER
12. Name John Kosker
13. Birthplace ?

MOTHER
14. Maiden Name Catherine Tykal
15. Birthplace ?

16 (a) Informant Mrs. Gertrude Kosker
(b) Address 2910 Bayonne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Hargord Road #14

19 (a) OCT 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17th 1948, at 4 P. M

21. I certify that death occurred on the date above stated: that I attended deceased from June 27 1945 to Oct 17 1948 and that I last saw h[illegible]M alive on Oct 17 1948.

Immediate cause of death: Cerebral Thrombosis — Duration: 6 wks

Due to: Generalized Arteriosclerosis — 5 yrs.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature George Kosker M.D.
Address 4808 Harford Rd. Date signed 10/18/48

VS 150

6772.9

Dr. Bawden
1517 E. North Ave.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 6677.9

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4317 Harford Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4317 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Flora Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Charles Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 1, 1865

8. AGE: Years	Months	Days	If less than one day
83	5	15	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Flora Cook
(b) Address 4317 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) OCT 18 1948 (Date rec'd by Registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16th 1948, at 12.40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1945 to Oct 16 1948
and that I last saw her alive on Oct 15 1948

Immediate cause of death: Myocardial insufficiency — Duration: 6 hrs
Due to: Coronary thrombosis — 3 days
Due to: Coronary sclerosis
Other Conditions: General arteriosclerosis. Diabetes.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 151 [illegible] Date signed 10/17/48

94a

G67760

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G67760 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 W. Mulberry Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: ERNEST HENRY GILSTER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-09-9277

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna M. E.

6 (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): May 9, 1884

8. AGE: Years: 64 Months: 5 Days: 6 If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: Baker

11. Industry or business: Anton Hazel Bakery

FATHER
12. Name: Henry Gilster
13. Birthplace: Germany

MOTHER
14. Maiden Name: Wilhelmina Meyer
15. Birthplace: Germany

16 (a) Informant: Mrs. Edna M. E. Gilster
(b) Address: 1925 W. Mulberry Street

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct. 19-48 (month) (day) (year)
(c) Cemetery or crematory WESTERN CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE, 17

19 (a) OCT 18 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948, at 4:05 PM

21. I certify that I took charge of the remains described above, held an Insp & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary artery disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner M.D.
Date signed 10-16-48

VS 151

67701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 67701

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Brooklyn Park (If outside city or town limits, write RURAL, and give town)
(d) Street No. 107 4th Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES BLAINE ENGLAR

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-7813

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Clara E.

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) April 19, 1882

8. AGE: Years 66 | Months 5 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Carroll County, Md. (Town, county, and state)

10. Usual Occupation Power House Operator

11. Industry or business Davidson Chemical Co.

FATHER
12. Name Benjamin Franklin Englar
13. Birthplace Maryland

MOTHER
14. Maiden Name May E. Perry
15. Birthplace Maryland

16 (a) Informant Mrs. Helen E. Bevans (Daughter)
(b) Address 1016 Andover Road

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Crematory
Location Baltimore, Maryland

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Place

19 (a) OCT 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1948, at 1.50 A.M.

21. I certify that I took charge of the remains described above, held an partial autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull & Intra-cranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following: 9/1

(a) Date of injury 10-15-48 at approx. 8.15 P.M.
(b) Where did injury occur? 1016 Andover Road
(c) Did injury occur at home, on farm, industrial place, in public place? friend's Home While at work? no
(d) Means of injury Fell down steps

23. Signature Earl R. Royer M.D. Medical Examiner.
Date signed October 18, 1948

X

6677-52

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ 6677-52 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No) If yes, name country

3 (a) FULL NAME ELLA ROSE MOELTER

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex F | **5. Color or race** W. | **6 (a) Single, married, widowed, or divorced** Married.

6 (b) Name of husband or wife Martin Moelter **6 (c) If alive, give age** years

7. Birth date of deceased (mo., day, yr) Feb. 10, 1883

8. AGE: Years 65 | Months 8 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Phillip McAleer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Kelleher
15. Birthplace Ireland

16 (a) Informant Mr. Martin Moelter (Husband)
(b) Address 1826 N. Dallas Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10-20-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) OCT 18 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1948 at 8:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1948 to Oct 16, 1948, and that I last saw her alive on Oct. 16, 1948.

Immediate cause of death Respiratory Failure — **Duration**

Due to Cerebral Hemorrhage

Due to Arteriosclerosis and Hypertensive C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank W. Baker, Jr. M.D.
Address St. Joseph's Hospital Date signed 10-16-48

VS 150

G67703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registration No. G67703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARION LISTON BROWN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Thomas B. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 16, 1883

8. AGE: Years	Months	Days	If less than one day
55	0	0	hr. min.

9. Birthplace Cambridge, Mass.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Johns Hopkins Hospital

FATHER
12. Name Edward Liston
13. Birthplace Boston, Mass.

MOTHER
14. Maiden Name Mary A. Seabury
15. Birthplace Boston, Mass.

16 (a) Informant Mrs. Philander Briscoe
(b) Address 209 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 18 1948 (Date rec'd by registrar) Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1948, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1929 to date 19 . and that I last saw him alive on after Oct 1948.

Immediate cause of death: Massive Coronary — Duration sudden

Due to: Hypertension

Due to: Last Injected for hi Oct 11 1948

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 12 Eager Date signed 10/15/48 M. D.

VS 193

QC-48-12240

G67704

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 4

8 1a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 1st
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 W North Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM DAVID FINECEY

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-24-48

8. AGE: Years 0 | Months 4 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name James R. Finecey
13. Birthplace Baltimore

MOTHER 14. Maiden Name Catherine B. Egan
15. Birthplace Baltimore

16 (a) Informant Father
(b) Address alone

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICHNER & SONS
(b) Address Balto., Md.

19 (a) OCT 18 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 17 - 1948, at 11:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13-1948 to 10-17-1948, and that I last saw him alive on 10-17-1948

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumococcal Meningitis	9 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allyn R. Judd M.D.
Address Mercy Hospital Date signed 10-17

VS 159

687765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

687765

Registered No. 84485

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: U S Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 53 days
(e) Length of stay in Baltimore (yrs., mos., or days): Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1237 N. Bentalou St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Joseph Ernest Watts

3 (b) If veteran, name war: SAW

3 (c) Social Security Account No.: 218-22-0293

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Margaret Schindhelm Watts

6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Oct. 21, 1878

8. AGE: Years: 69 | Months: 11 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: None (Barber -retired)

11. Industry or business: None (self)

FATHER
12. Name: Thomas Watts
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Rebecca Correll
15 Birthplace: Maryland

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/20/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 18 19[illegible] (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 16 1948, at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1948 to Oct 16 1948 and that I last saw h[illegible] alive on Oct 16 1948

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchogenic carcinoma with	
Due to atelectasis and emphysema	over
Other Conditions Diagnosed	

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy: Bronchogenic carcinoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Edward H. Jayne M.D.
Address: V.S.M.H. Balto Date signed 10/16/48

V S 150

67706 ✓ 67706

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164E

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lombard & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 25-
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore, 6
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 3427 Sunlea Court
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country:

3 (a) FULL NAME: GEORGE C. HUNSUCKER

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth

6 (c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): 12-17-17

8. AGE: Years: 30 | Months: 10 | Days: 0 | If less than one day: ..... hr. ..... min.

9. Birthplace: Robbins N. Carolina
(Town, county, and state)

10. Usual Occupation: Burner

11. Industry or business: Beth. Steel

FATHER
12. Name: George C. Hunsucker
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Katie Short
15. Birth place: N. C.

16 (a) Informant: Ruth Hunsucker
(b) Address: 3427 Sunlea Court

17 (a) Removal (Burial, cremation, or removal) **(b) Date thereof:** 10/19/48 (month) (day) (year)
(c) Cemetery or crematory: ROBBINS
Location: ROBBINS N. CAROLINA.

18 (a) Funeral director: Wm. Cook Inc.
(b) Address: 1217 St Paul St.

19 OCT 19 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: October 17, 1948, at 10:30 M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of skull & Internal hemorrhage

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: 10-16-48 **at** Approx. 4:55 P. M.
(b) Where did injury occur? Brager-Eisenberg's Dept. Store
(c) Did injury occur at home, on farm, industrial place, in public place? Public **While at work?** No
(d) Means of injury: Jumped from second fl. window

23. Signature: [signature] M.D.
Medical Examiner

Date signed:

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

Registered No. 66777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GLEN FRANK BAMBERGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1881

8. AGE: Years	Months	Days	If less than one day
67	6	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Westendorf Mfg. Co.

FATHER
12. Name Joseph W. Bamberger
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Virginia C. Poole
15. Birthplace Baltimore, Md.

16 (a) Informant John P. Bamberger
(b) Address 405 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 19 1948 (Date rec'd by Registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18, 19 48, at 1:10 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inc. Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 18/48 From 7:30 A.M. to approx. 12 noon P.M.
(b) Where did injury occur? 405 E. Preston St. Cellar
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hung self with necktie

23. Signature John R. Davis, Medical Examiner, M.D.
Date signed 10/18/48

VS 151

6677 58

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. 6677 58

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 W. Cross St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 W. Cross St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Becker

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-3102

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Mary E. Becker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 11 1873

8. AGE: Years	Months	Days	If less than one day: hr.	min.
74	11	6		

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired Truck Driver
11. Industry or business Barton, Duer & Koch

FATHER
12. Name Becker
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Marie Talbott
(b) Address 17 W. Cross St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 OCT 19 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1948, at 7 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 15 1948 to Oct 17 1948 and that I last saw him alive on Oct 17 1948

Immediate cause of death Chronic Myocarditis (non Rheumatic) (with Edema) — Duration 10 yrs.
Due to
Due to
Other Conditions Chronic nephritis.
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature James E Peterman
Address 1206 Hanover St Date signed 10/18/48 M.D.

VS 150

92 D

Ward 9 Asl. 4

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

939

Registered No. 6[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 939 Aisquith Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mabel M. [redacted] Cutler

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank A.
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) 11-11-76

8. AGE: Years	Months	Days	If less than one day
71	11	4	hr. min.

9. Birthplace R. I. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wellcome Foy
13. Birthplace Me.

MOTHER
14. Maiden Name ? Longfellow
15. Birthplace ? R. I.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (b) Date thereof 10/19/48 (month) (day) (year)
(c) ~~Cemetery~~ crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cost Inc
(b) Address 1217 St. Paul St.

19 (a) 10 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15 1948 at 6.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2 1948 to 10-15 1948 and that I last saw her alive on 10-15 1948

Immediate cause of death: Bronchopneumonia — Duration: Days.
Due to Chronic Pulmonary Disease & Pulm Emphysema — years. / years.
Due to — years.
Other Conditions Arteriosclerotic Hd. Disease

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Bronchopneumonia, Myocardial Scarring

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Anthony J. Izzo M. D.
Address The Johns Hopkins Hosp. Date signed 10-16-48

VS 199

107

6777 Brady 2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

135a

Registered No. 6777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Kensington (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Francis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Josephine Francis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-3-99

8. AGE: Years	Months	Days	If less than one day
49	4	14	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Attorney
11. Industry or business

FATHER	12. Name George Francis
	13. Birthplace Va.
MOTHER	14. Maiden Name Mary Ewat
	15. Birthplace Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-48 (month) (day) (year)
(c) Cemetery or crematory Harmony Cem.
Location: Wash. D. C.

18 (a) Funeral director Mrs Samuel T. Hemsley
(b) Address 578 W. Biddle Street

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1948, at 7 P. M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10-1 1948, to 10-17 1948, and that I last saw him alive on 10-17 1948

Immediate cause of death pulmonary embolism — Duration 1 min

Due to

Due to

Other Conditions hydronephrosis — 10 yrs

(Include pregnancy within 3 months of death)

Date of operation 10-15-48

Major findings of operation: resection neck obstruction

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. E. Beckmann, M.D.
Address Johns Hopkins Hosp
Date signed 10/18/48

VS 150

57771

BALTIMORE CITY HEALTH DEPARTMENT ✓ 667771

BC- 48-24413 CERTIFICATE OF DEATH 15TH Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So. Balt. Gen. Hosp. 21-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town S.B.G.H. Balto. (If outside city or town, write RURAL and give town)
(d) Street No. 1116 Aisquith (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Albert Elliott

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/10/48

8. AGE: Years | Months | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name George Elliott

13. Birthplace —

MOTHER 14. Maiden Name Eva Jemick

15. Birthplace Balt. Md.

16 (a) Informant Eva Jemick

(b) Address Balt. Md. 1116 Aisquith

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19 1948 (month) (day) (year)

(c) Cemetery or crematory The First German United Evangelical Church Cem

Location 6-10 E. Monument Sts

18 (a) Funeral director Joseph Rauschkolb Jr

(b) Address 604 Washington Blvd

19 (a) OCT 19 1948 (Date rec'd by Registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18 1948, at 5:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/10 1948 to 10/18 1948, and that I last saw h[illegible] alive on 10/18 1948

Immediate cause of death: Uremia — Duration: 8 days

Due to Bilateral Pyelonephritis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Same as above

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan C Richards M. D.

Address S. Balto. Gen. Hosp. Date signed 19 Oct 48

VS 150

77 72

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6677 72

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4206 Maine Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 Maine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Ellis Terrier
3 (b) If veteran, name war
3 (c) Social Security Account No. 705-05-3933
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 24, 1884
8. AGE: Years 63 | Months 9 | Days 24 | If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation B&O Railroad
11. Industry or business
FATHER 12. Name William R. Packard
13. Birthplace Virginia
MOTHER 14. Maiden Name Leonora Seltzer
15. Birthplace Baltimore Md.
16 (a) Informant Elmer S. Terrier
(b) Address 4206 Maine Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20, 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.
18 (a) Funeral director Ellsworth, Armour
(b) Address 3911 Liberty Heights Ave.
OCT 19 1948 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18th 1948, at 1:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 27 1948, to Oct 18 1948, and that I last saw h/m alive on Oct 18 1948.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Thos D Bubert M. D.
Address 4803 Park Heights Ave Date signed 10/18/48

VS 150

57773

387689

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

75C

G67773 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 W. Hoffman, St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FANNIE Britt.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Obadiah Britt

6 (c) If alive, give age ? years

7. Birth date of deceased mo., day, yr: 4-16-86

8. AGE: Years: 62 | Months: 6 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Va. (Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business

FATHER
12. Name: Obie Britt
13. Birthplace: Va.

MOTHER
14. Maiden Name: Kate Mosby
15. Birthplace: Va.

16 (a) Informant: JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: Oct 20 /48 (month) (day) (year)
(c) Cemetery or crematory
Location: Brookland County Va

18 (a) Funeral director: Mrs. Robt. A. Elliott Daughty
(b) Address: 1129 N. Caroline St

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 18- 1948 at 1 15- A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8- 1948 to 10-18- 1948 and that I last saw her alive on 10-18- 1948.

Immediate cause of death: anoxia — Duration

Due to: Hypoplastic anemia

Due to: possible chronic myeloid leukemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Enlarged liver & spleen

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature: John Odgen Harvey M.D.
Address: Johns Hopkins Hospital 10-20-48

737

67714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20

Registered No. 67714

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1013 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eudia Alston

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-14-99

8. AGE: Years 49 | Months 6 | Days 2 | If less than one day: hr. min.

9. Birthplace N C (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edmund Faulkner
13. Birthplace ?

MOTHER 14. Maiden Name Annie Johnson
15. Birthplace ?

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md

18 (a) Funeral director Mrs. Robt. A. Elliott Dept
(b) Address 1129 N. Carolina St

OCT 19 1948 (Date rec'd by registrar) Contractor Williams, Md

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Oct 16 - 1948 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3-1948 to 10-16-1948 and that I last saw her alive on 10-16-1948

Immediate cause of death Pertonitis and intra abdominal hemorrhage — Duration 2 days

Due to Tuberculous Psoas abscess — 8 months

Due to

Other Conditions Aneurysm aorta ABDOMINAL AORTA — 5

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Peritonitis and psoas abscess

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Marion C. Andrews M.D.
Address Johns Hopkins Hospital Date signed 10-18-48

16

VS 150

Stamp 5 Brandy 2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66775

127a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Glenarm (If outside city or town limits, write RURAL and give town)
(d) Street No. Copper Factory Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Morgan

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Sarah Morgan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-?-65

8. AGE: Years	Months	Days	If less than one day
83	1		hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Jarrate Morgan
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Billington
15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Gilboa
Location Long Green, Md.

18 (a) Funeral director Wm. T. Chatman Jr
(b) Address 1701 Mt. Cullob St.

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Billington Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1948, at 8:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1948, to 10-17 1948, and that I last saw him alive on 10-17 1948.

Immediate cause of death	Duration
Uremia	10 days
Due to Benign prostatic hypertrophy	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. E. Beckmann
Address Johns Hopkins Hosp
Date signed 10/18/48 (M D)

VS 150

6776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6776

1202

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Union Bridge, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev Richard Miller

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Eleanor Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1919

8. AGE: Years	Months	Days	If less than one day
29			hr. min.

9. Birthplace York Pa (Town, county, and state)
10. Usual Occupation Preacher
11. Industry or business

FATHER	12. Name	Norman Miller
	13. Birthplace	Pa
MOTHER	14. Maiden Name	Verna Bohn
	15. Birthplace	Pa

16 (a) Informant Eleanor Wilson
(b) Address Union Bridge, Md
17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10 21 48 (month) (day) (year)
(c) Cemetery or crematory York City
Location York Pa
18 (a) Funeral director Raymond L Wright
(b) Address Union Bridge, Md
19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 19 48, at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 19 48 to Oct 15 19 48
and that I last saw h[illegible] alive on Oct 15 19 48

Immediate cause of death Respiratory Failure — Duration

Due to Surgical procedure

Due to

Other Conditions Cirrhosis

(Include pregnancy within 3 months of death)

Date of operation Oct 12 1948

Major findings of operation: Pancreatic Cyst

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Frank E Blumbach M.D.
Address University Hosp Date signed 10/19/48

VS 150

67777 BC-48-09007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122 B

✓ 67777 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address University Hosp

(c) Hospital or institution Baltimore Md 16-4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 dy

(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County (Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 1009 Mc Kean Ave #17 (If rural, give location)

(e) Citizen of foreign country? None (Yes or No)

If yes, name country

3 (a) FULL NAME Ernest Mills

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. baby

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/23/48

8. AGE: Years — Months 6 Days 26 If less than one day hr. min.

9. Birthplace Balt Md (?) (town, county, and state)

10. Usual Occupation baby

11. Industry or business

FATHER 12. Name Ernest Mills

13. Birthplace md

MOTHER 14. Maiden Name Dorothy Mates

15. Birthplace md

16 (a) Informant Dorothy Mills

(b) Address 1009 Mc Kean Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location B. C. County, Md

18 (a) Funeral director Joseph B. Locke

(b) Address 1304 N. Central Ave

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18-48 19 , at 6 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1948 to 10-18 1948, and that I last saw h AM alive on 10-18-48 19.

	Duration
Immediate cause of death (Post oper. shock fail oper. for — Intussusception	
Due to Meckel's Diverticulum	
Due to and an Intussusception	
Other Conditions of terminal ileum & ascending & transverse colon	

(Include pregnancy within 3 months of death)

Date of operation 10-16-48

Major findings of operation: Meckel's Diverticulum & intussusception (see above).

of autopsy: Surgical terminal ileum

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R. C. Hunter, M.D.

Address Univ. Hosp. Date signed 10-18-48

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 150

66778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 66778

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1414 N. Central Ave
(c) Hospital or institution: 9.9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 N. Central Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victoria Golden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C.	Married

6 (b) Name of husband or wife Lafeyette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 7. 1879

8. AGE: Years	Months	Days	If less than one day
69	1	10	hr. min.

9. Birthplace Clinton, S.C.
(Town, county, and state)
10. Usual Occupation Pensioner
11. Industry or business

FATHER
12. Name Joseph Suber
13. Birthplace S.C.

MOTHER
14. Maiden Name Lavinia Hunter
15. Birthplace S.C.

16 (a) Informant Eula McMorris Clyburn
(b) Address 1414 N. Central Ave.

17 (a) Removal (b) Date thereof 10-21-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Clinton, S.C.

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 1304 N. Central Ave

19 (a) OCT 19 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 19 48, at 12:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 19 48 to 10/17 19 48 and that I last saw h e v alive on 10/6 19 48

Immediate cause of death Myocardial Failure — Duration

Due to Hypertensive C-V Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Proctor Grant M.D.
Address 601 N. Carrollton Date signed 10/19/48

VS 153

67779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 67779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1027 Ashburton St.
(c) Hospital or institution: 16-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 Ashburton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas L. Dawson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, ~~1907~~ 1908

8. AGE: Years 40 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Station Manager

11. Industry or business American Oil Co.

FATHER
12. Name Thomas L. Dawson
13. Birthplace Md.

MOTHER
14. Maiden Name Frances A. Staylor
15. Birthplace Md.

16 (a) Informant: Mr. William L. Dawson
(b) Address 1027 Ashburton St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/20/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 19 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Oct. 1948 at 11:20 ~~P~~ A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. N. Kamman, M.D. Medical Examiner.
Date signed 18 Oct. 48

67780

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67780

164c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Longwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD R. HOPKINS

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Letitia Hopkins

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 6, 1929

8. AGE: Years: 19 | Months: 6 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Camac Trainer

11. Industry or business:

FATHER
12. Name: Russell Hopkins
13. Birthplace: Va.

MOTHER
14. Maiden Name: Elizabeth Ziegler
15. Birthplace: Balto.

16 (a) Informant: Mrs. Elizabeth Altvater
(b) Address: 1721 Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)

(c) Cemetery or crematory: Meadowridge
Location: Howard Co., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1948 at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of Brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 17/48 at 11:15 A.M. A.M.
(b) Where did injury occur? 400 ft. behind the Laurel Park Grill
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury: Firearms

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed 10/18/48

67781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G67781 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3706 Menlo Drive.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 20
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 Menlo Drive. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME SOLOMON SENKER.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-5972

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sarah W. Senker.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1875.

8. AGE: Years	Months	Days	If less than one day
72	11	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name Samuel Senker,
13. Birthplace Austria.

MOTHER
14. Maiden Name Babette Greenhood,
15. Birthplace Germany.

16 (a) Informant Mrs. Sarah W. Senker,
(b) Address 3706 Menlo Drive.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Baltimore, Md.

18 (a) Funeral director Harris Sonneborn & Son
(b) Address 1902 Eutaw Place.

19 (a) OCT 19 1948 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18th. 1948 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3rd 1948 to 18 Oct 1948, and that I last saw h[illegible] alive on 18 Oct 1948.

	Duration
Immediate cause of death: Coronary thrombosis / Pulmonary edema	4 hours
Due to: Hypertension / Atherosclerosis	10 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis P. Hamburger Jr. M.D.
Address 1207 Eutaw Place. Date signed 10-20-48

VS 150

67782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

Registered No. 67782

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 N. Dallas Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ARTHUR BROOKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 11, 1917

8. AGE: Years 30 | Months 11 | Days 4 | If less than one day hr. min

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Sparrows Pt.

FATHER
12. Name Earl Brooks
13. Birthplace North Carolina

MOTHER
14. Maiden Name Minnie
15. Birthplace Faulkner, North Carolina

16 (a) Informant: Mrs. Minnie Brooks
(b) Address, 1002 N. Dallas Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 19 48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Cem.
Location

18 (a) Funeral director Chas. O. Wilson
(b) Address 1005 Edmondson Ave

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Insp.& Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: L. W. Burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-11-48 at 8:20 A. M.
(b) Where did injury occur? Sparrows Point Shipyard
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Covered with hot flue dust

23. Signature Earl V. Ryan, M.D. Medical Examiner.
Date signed 10-16-48

VS 151

1677783

MH 123367

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1312

Registered No. 1677783

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2010 W. Lanvale Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Lillian Moseley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Richard Moseley
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr: 5/9/1898

8. AGE: Years 50 | Months 5 | Days 7 | If less than one day: hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Brown
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace N.C.

16 (a) Informant Balto. City Hosp. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem. Brooklyn Md
Location

18 (a) Funeral director Elroy V. Wilson
(b) Address 1003 Brantley ave

19 (a) OCT 19 1948 (Date rec'd by Registrar) (b) Evington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16/48 19 at 2:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29- 1948 to 10-16- 1948 and that I last saw her alive on 10-16- 1948

Immediate cause of death: Chronic nephritis - uremia — Duration

Due to (a)

Due to

Other Conditions Cardiac decompensation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. V. Wilson M. D.
Address Baltimore City Hospitals Date signed 10-17
4940 Eastern Ave.

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

567784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 567784

1 2

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1138 N. Whatcoat Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 1138 Whatcoat Street (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Edna Mae Glover Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No. 249-34-4722

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	M

6 (b) Name of husband or wife Robert Kelly

6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Sept 14th, 1921

8. AGE: Years	Months	Days	If less than one day
27	1	1	hr. min.

9. Birthplace Ellison S.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Gene Glover

13. Birthplace Ellison S.C.

MOTHER

14. Maiden Name Bertha Reid

15 Birthplace Ellison S.C.

16 (a) Informant Robert Kelly

(b) Address 1138 Whatcoat Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Brooklyn, Maryland

18 (a) Funeral director Joseph L. Russ

(b) Address 1200 McCulloh Street

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1948 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1948 to 10-15 1948.

and that I last saw h alive on 19

Immediate cause of death	Duration
Pulmonary Hemorrhage	
Due to T B. advanced Stage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Wm R. Boykin M.D.

Address 1133 Monroe Date signed 10/19/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 657785

57785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Bernice ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 S. Bernice ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Virginia Harris

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-05-1125

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Wm. C. Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 19-1912

8. AGE: Years 36 | Months 8 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Ladies' Tailoring

11. Industry or business —

FATHER
12. Name Theodore Peters
13. Birthplace Md

MOTHER
14. Maiden Name Julia Pilkerton
15. Birthplace Md

16 (a) Informant Mrs. Julia Peters
(b) Address 22 S. Bernice ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md

18 (a) Funeral director Geo. K. Beyer Jr
(b) Address 1512 Collins St.

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17- 1948, at 11.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1948, to Oct 17 1948, and that I last saw her alive on Oct 17 1948.

Immediate cause of death: Carcinoma of Colon — Duration: 1½ yrs
Due to with metastasis to liver & lung
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Israelson
Address 2158 W. North Ave Date signed 10/19/48

VS 153

657786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109a

Registered No. 657786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CARRIE AMELIA LANGLEY

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-20-3763A

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 11, 1873

8. AGE: Years 75 | Months --- | Days 6 5 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Sampson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alice Peck
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ethel Langley Williams
(b) Address 1241 Irving St. Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk. Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 OCT 19 1948 (Date rec'd by Registrar) (b) Penelope Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1948, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10.15. 1948, to 10.16 1948, and that I last saw h er alive on 10.16. 1948.

Immediate cause of death: Primary atypical pneumonia (viral pneumonia)

Duration: 9 days

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James D. Carr M.D.
Address 515 Mulberry St Date signed 10.19.48

VS 150

677787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 677787

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 N. Carey Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT T. CASSELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ———

6 (c) If alive, give age——— years

7. Birth date of deceased (mo., day, yr.) March 14, 1933

8. AGE: Years 15 | Months 7 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation ———

11. Industry or business

FATHER
12. Name Charles H. Cassell
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Frances Penning
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Frances Cassell
(b) Address 524 N. Carey Street

17 (a) Burial (b) Date thereof Oct. 19, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Wm. George A. Hall & Son
(b) Address 1631 Druid Hill Ave

19 (a) OCT 19 1948 (b) Interred in Williamsport, Md.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

45

20. DATE OF DEATH 10-18- 1948 at 11:A M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lymphoblastoma, generalized

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.

Date signed 10-18-48

X

667788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

667788 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore Carroll
(c) City or town Whitehall
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME W. Evans Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Maried

6 (b) Name of husband or wife Elva Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1 1867

8. AGE: Years	Months	Days	If less than one day
81	1	18	hr. min.

9. Birthplace Whitehall (Town, county, and state) Maryland
10. Usual Occupation Magistrate
11. Industry or business Law

FATHER
12. Name John Anderson
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Kirkwood
15. Birthplace Maryland

16 (a) Informant church record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21-48 (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Whitehall Rural

18 (a) Funeral director Howard S. Mackelvan
(b) Address Whitehall Md

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1948, at 3.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1948 to Oct. 19 1948.
and that I last saw him alive on Oct. 19 1948.

Immediate cause of death Anuria — Duration 96 h.

Due to arteriosclerosis, generalized

Due to

Other Conditions Cerebral thrombosis 96 h.
atelectasis, rt. lung
(Include pregnancy within 3 months of death)

Date of operation 10/14/48

Major findings of operation: Ca of st.
colon

of autopsy: confirms above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Robert Deaver, M.D.
Address Church Home Date signed 10/19/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66789

66789 46B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3508 Bank St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DR MORRIS SCHEINDLINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Leona (Mc Kenzie)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1892

8. AGE: Years	Months	Days	If less than one day
56	9	1	hr. min.

9. Birthplace RUMANIA
(Town, county, and state)

10. Usual Occupation MEDICAL DOCTOR

11. Industry or business

FATHER
12. Name Unk
13. Birthplace

MOTHER
14. Maiden Name Unk
15. Birthplace

16 (a) Informant Mrs. Leona (Mc Kenzie)
(b) Address 3508 Bank St

17 (a) Burial (b) Date thereof Oct. 19-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Md

18 (a) Funeral director John B Connelly
(b) Address 418 Eastern Ave.

19 (a) OCT 19 1948 (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1948 at 7:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1948 to 10/16 1948. and that I last saw h[illegible] alive on 10/16 1948.

Immediate cause of death CACHEXIA & UREMIA — Duration

Due to GENERALIZED CARCINOMATOSIS

Due to

Other Conditions SCHONLEIN's PURPURA
(Include pregnancy within 3 months of death)

Date of operation 10/10/48

Major findings of operation: Generalized Carcinoma

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Lyons M. D.
Address Sinai Hospital Date signed 10/16/48

VS 150

Important: Physicians, please write the causes of death clearly and legibly.

67750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 67750

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2007 Belair Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Belair Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Dieter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 21 - 1868

8. AGE: Years 79 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Emanuel Manner
13. Birthplace Balto

MOTHER
14. Maiden Name Anna Kellerman
15. Birthplace Balto

16 (a) Informant Mr Jacob Dieter
(b) Address 2007 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jos. Herr & Son
(b) Address 3901 Kentucky ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17- 1948 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2- 1938 to 10-16-1948 and that I last saw her alive on 10-16-1948.

Immediate cause of death	Duration
Acute Myocardial Infarction	1/2 hr.
Due to Hypertension	10 yrs
Due to Cardio-vascular renal Disease	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Milton C. Lang
Address 2017 Belair Rd Date signed 10-18-48 M D

VS 150

667791

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 152

667791 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Str
(c) Hospital or institution: University Hosp. 14 out 5 days
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Argyle Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Green

3 (b) If veteran, name war	3 (c) Social Security Account No.
?	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? 1902

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace King & Queen's Co. Va. (Town, county, and state)
10. Usual Occupation laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Sister in law Clara Green
(b) Address 516 St Mary's St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna Ave

19 OCT 19 1948 (Date rec'd by Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1948, at 1.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12-1948 to 10-16-1948 and that I last saw h/m alive on 10-16-1948.

Immediate cause of death	Duration
condro-sarc. of bone	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H Conner M D M. D.
Address University Hosp Balto, Md Date signed 10-19-48

VS 150

Please write the cause of death clearly and legibly.

G67792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G67792 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 626 North Hilton Street
(c) Hospital or institution: 1 1 1 1 1 1 1 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1 1 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 North Hilton Street
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY SAWYER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife / / / /

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 23-1873

8. AGE: Years 75 | Months 1 | Days 23 | If less than one day ► ********** hrs. ********** min.

9. Birthplace Harford County, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Sawyer
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Burke
15. Birthplace Maryland

16 (a) Informant Mr. W.A.Williams
(b) Address 626 North Hilton Street

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct. 20/48 (month, day, year)
(c) Cemetery or crematory St. Mary's
Location Belair Maryland

18 (a) Funeral director JOHN O. MITCHELL & SONS
(b) Address 1500 EUTAW PLACE...17

19 (a) OCT 19 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 16 / 1948 at 8 A.M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: Natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis, M.D. Medical Examiner.
Date signed 10-16-48

VS 151

G67793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G67793 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 826 Ashland Court
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 826 Ashland Court (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No) If yes, name country

3 (a) FULL NAME Robert E. Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Emma L. Cook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 29, 1863

8. AGE: Years	Months	Days	If less than one day
85	1	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name William Price
13. Birthplace

MOTHER
14. Maiden Name Mary Stone
15. Birthplace England

16 (a) Informant Mr. Ross Tarr
(b) Address 1801 Selma Ave. Halethorpe, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Cambridge, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) OCT 19 1948 Date rec'd by registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1948 12:25 P M

21. I certify that death occurred on the date above stated, that I attended deceased from May 18 48 to Oct. 18 1948, and that I last saw him alive on Oct. 18 1948.

Immediate cause of death Pneumonia — Duration 8 hrs.

Due to myocardial degeneration, 4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. R. Johnson M. D.
Address Medical Arts Bldg. Date signed

VS 150

66794 BC= F-1-227 55

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. 66794

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: UH.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County Anne Arundel
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Stoop (If rural give location)
Lot 398 R 19
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Kenneth Bruce Alonzo Murray

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/13/48

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation Infant.

11. Industry or business

FATHER 12. Name Kenneth Bernard Murray
13. Birthplace Philadelphia Pa

MOTHER 14. Maiden Name Margaret Rose King
15. Birthplace Balto, Md

16 (a) Informant Margaret Murray
(b) Address Box 398 Rt 9, Brooklyn Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Leo B. Kelson
(b) Address 1808 Presstman St

19 (a) OCT 19 1948 (b) Kenneth for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 1948 at 7:24 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13 1948 to 10/17 1948 and that I last saw him alive on 10/17 1948

Immediate cause of death C-R Failure — Duration

Due to Prematurity

Due to

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Auerbach M. D.
Address UH Date signed 10/18

67795

JL - 61573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 67795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 925 S. Fremont Ave.
(If rural, give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME
Peter Farrington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 20, 1875

8. AGE: Years 73 | Months 3 | Days 26 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: James
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Dowd
15. Birthplace: Ireland

16 (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (yr.)
(c) Cemetery or crematory: Jacob Heaps Comm
Location: Georgetown Hyde Rd

18 (a) Funeral director: John J. Cowan Jr
(b) Address: 901 Hollins St
Huntington Williams M.D.

OCT 19 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 16 1948, at 10PM M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec. 4 1940 to Oct. 16 1948, and that I last saw him alive on Oct. 16 1948.

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions: Arteriosclerosis Cardiovascular Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: William H. Verkes Jr. M.D.
Address: Balto City Hosp Date signed 19 Oct 48

107

VS 350

67796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 67796 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3913 Woodbine Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3913 Woodbine Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lizzie Ann Venable

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married, widowed,~~ or ~~Divorced~~ Widowed

6 (b) Name of husband or wife Addison A. Venable

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) February 6, 1870

8. AGE: Years 78 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace Fairmont, Somerset, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John C. Thomas
13. Birthplace Somerset Md.

MOTHER
14. Maiden Name Emily Jane Revell
15. Birthplace Marion Md.

16 (a) Informant Alice V. Middleton
(b) Address 404 Eutaw Place, Balt. 17 Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10 19 48 (month) (day) (year)
(c) Cemetery or crematory Bradshaw Funeral Home
Location Crisfield Maryland

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto 31 Md.

19 OCT 19 1948 (Date rec'd by registrar) (b) Carrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1948 at 11 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1948 to Oct 18 1948 and that I last saw her alive on Oct 18 1948

Immediate cause of death Congestive Heart Failure — Duration 18 hours

Due to Arteriosclerotic Cardiovascular Disease — 3 years

Due to

Other Conditions Hypertensive Cardiovascular Disease — 2 years
(Include pregnancy within 3 months of death)

Date of operation None done

Major findings of operation: None done

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Millard T. Traford Jr.
Address 3400 Woodbine Ave. - 7 Date signed 10/18/48

VS 150

Especially important. Physicians: please write the causes of death clearly and legibly.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

667797

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 667797 Registered No. 927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 E Baltimore St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Rachel B Axelrod

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Rev Aaron Axelrod

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1866

8. AGE: Years	Months	Days	If less than one day ?
82			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House life

FATHER
12. Name Solomon Resnick
13. Birthplace Russia

MOTHER
14. Maiden Name Pesha
15. Birthplace Russia

16 (a) Informant Rev Aaron Axelrod
(b) Address 1122 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cem
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) OCT 19 1948 (Registered by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1948 at 4:30 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Oct 18 1948 and that I last saw h alive on Oct 18 1948

Immediate cause of death: General arteriosclerosis / Chronic myocarditis — Duration: 5 yrs / 5 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Helen L. Solomon

Address 129 S. Broadway Date signed 10/18/48

VS 150

677798

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

677798 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green St
(c) Hospital or institution: University Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3714 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MYER CHAPNEK

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 15, 1892

8. AGE: Years	Months	Days	If less than one day
56	7	3	hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation merchant
11. Industry or business

FATHER
12. Name Chapanek.
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informan: Rose Chapnik
(b) Address 3714 Eastern Ave

17 (a) Burial (b) Date thereof Oct 20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E. Baltimore St

18 (a) Funeral director Sol Hyrman Bur
(b) Address 1124-26 N. North ave

19 (a) OCT 19 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1948, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 04 17 1948 to 04 18 1948, and that I last saw h[illegible] alive on 04 18 1948.

Immediate cause of death — **Duration**

Cardiac arrest

Due to coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 10, 18, 48

VS 150

G67799

464968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

G67799 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 E. 41st. Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Leon Joseph L. Bozman.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Clara Bozman
6 (c) If [illegible], give age 57 years

7. Birth date of deceased (mo., day, yr) [illegible]-25-89

8. AGE: Years	Months	Days	If less than one day
59	6	24	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation accountant
11. Industry or business

FATHER 12. Name Joseph O. Bozman
13. Birthplace Md.

MOTHER 14. Maiden Name Ida Rogers
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-48 (month) (day) (year)
(c) Cemetery or crematory Lowden Park
Location Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3006 E. Baltimore St

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 1948 at 7:05 A M

21. I certify that death occurred on the date above stated: that I attended deceased from 10-9-1948 to 10-18-1948. and that I last saw him alive on 10-18-1948

Immediate cause of death Intestinal obstruction — Duration

Due to carcinomatosis

Due to carcinoma of stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/12/48

Major findings of operation: Carcinomatosis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John T. Grayhack M. D.
Address SH Date signed 10/19/48

John T. Grayhack

667800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667800

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3707 E.Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 E.Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Giovanni or John B. Papparotto

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 218-03-4817

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late Perina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1879

8. AGE: Years 69 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Torsi Italy
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Pietro Papparotto
13. Birthplace Italy

MOTHER
14. Maiden Name Adelaide Sacilletto
15. Birthplace Italy

16 (a) Informant Lena Papparotto (Daughter)
(b) Address 3707 E.Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20 1948 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave

18 (a) Funeral director Fraull Della Rose
(b) Address 322 S. High St.

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17-48 19 , at 7:55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-48 19 , to 10-17-48 19 , and that I last saw h in alive on 10-17-48 19 .

Immediate cause of death Cerebral Thrombosis — Duration 3 days

Due to Arteriosclerosis

Due to

Other Conditions Gangrene of feet

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Costantino, M.D.

Address 234 Hamburg St. Date signed 10-19-48

VS 150

667801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. 667801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3612 Woodbine Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3612 Woodbine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA M. KING

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jack King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Oct. 4, 1889

8. AGE: Years: 59 | Months: 0 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Edward Laurence
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Sarah Stampe
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Jack King
(b) Address: 3612 Woodbine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/48 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

(a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1948, at 8:35p M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Oct 17 1948, and that I last saw h alive on Oct 17 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 hrs

Due to: Hypertension Cardiovascular Disease — 10 yrs

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr Thos A Abell M. D.
Address 4509 Liberty Heights Date signed 10-18-48

VS 130

667803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

Registered No. 667803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 E. Lombard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISAAC TOMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: ———

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1902

8. AGE: Years 45 | Months 11 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informan: Ralph Toms
(b) Address 230 N. Durham Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, Maryland

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Avenue

19 (a) OCT 19 1948 (Date received by registrar) (b) Huntington for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION 15

20. DATE OF DEATH October 15, 1948, at 11: A. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 10/15/48

G67803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. 46780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or Institution: St. Joseph's 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 Byrd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret Reimer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife Herbert F. Reimer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1902

8. AGE: Years	Months	Days	If less than one day
46	6	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Hwfe. & Employee
11. Industry or business Court Square Bldg.

FATHER
12. Name Francis C. Hartlove
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary W. Neill
15. Birthplace Balto. Md.

16 (a) Informant Mrs Mary W. Hartlove
(b) Address 1728 Byrd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21-1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral,
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (c) OCT 19 1948 (Date received by Registrar) (b) Huntington Williams, M.D. (Registrar) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1948, at 6:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28, 1948 to Oct. 18, 1948, and that I last saw her alive on Oct. 18, 1948

Immediate cause of death	Duration
Hanot's Cirrhosis of Liver	
Due to	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Cirrhosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ray E. Parsons Jr. M. D.
Address 1 Joseph's Hosp. Date signed 10/18/48

VS 150

667804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

667804
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: C Hunch Home and Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 4
(e) Length of stay in Baltimore (yrs., ~~mos., days~~) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Stevenson
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jay Monroe Steigelman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Steigelman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-15-07

8. AGE: Years 41 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Dentist

11. Industry or business

FATHER
12. Name Steigelman, George
13. Birthplace Penna

MOTHER
14. Maiden Name Morrison, Florence
15. Birthplace Penna

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20-1948 (month) (day) (year)
(c) Cemetery or crematory St. Thomas
Location Garrison Forest, Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) OCT 19 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1948. at 8 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1948. to Oct 18 1948. and that I last saw him alive on Oct 17 1948.

Immediate cause of death Carcinoma of bladder & metastases Sigmoid colic Vesical fistula

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I G Fohlenmann M. D.
Address Church Home + Hosp Date signed 18 Oct 48

VS 150

X

G67805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

G67805

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton + Wilkens ave.

(c) Hospital or institution:

St. Agnes Hospital. 27

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State M. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. St. Marys. Roland Park - (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Rev. Philip J. Blanc. S.S.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1875

8. AGE: Years	Months	Days	If less than one day
73	—	—	— hr. — min.

9. Birthplace France (Town, county, and state)

10. Usual Occupation Priest.

11. Industry or business

FATHER

12. Name Laurence Blanc

13. Birthplace France

MOTHER

14. Maiden Name Mary P. France

15. Birthplace France

16 (a) Informant Father Sam Bocker -

(b) Address St. Marys Roland Park.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ St Charles

Location Lafayette

18 (a) Funeral director Kell-Mead ~~& Sons~~

(b) Address 805 N. Calvert St.

19 (a) OCT 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18/ 1948, at 1 35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1948 to 10/18 1948 and that I last saw him alive on 10/17 1948.

Immediate cause of death Acute cardio respiratory failure — Duration

Due to Adeno-Carcinoma of Head of Pancreas with

Due to Metastasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/15/48

Major findings of operation: Ca of Head of Pancreas with Metastasis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Stephen N. Padovano M. D.

Address St. Lyons Hosp. Date signed 10/18/48

VS 150

X

G7806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67806 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 W. Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. ~~(Start)~~ Stortz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Gussie ~~(Start)~~ Stortz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 30th 1877

8. AGE: Years	Months	Days	If less than one day
71	8	17	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired Policeman
11. Industry or business B & O R.R.

FATHER 12. Name Sidney S. ~~(Start)~~ Stortz
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary Shackelford
15. Birthplace Balto. ~~county~~ Md.

16 (a) Informant Gussie ~~(Start)~~ (Wife)
(b) Address 2215 W. Lexington St.

17 (a) Burial (b) Date thereof 10/21/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 OCT 20 1948 Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17th 1948 at 5:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1948 to 10/17 1948 and that I last saw him alive on 10/17 1948.

Immediate cause of death Bronchiectasis — Duration 6 mos

Due to

Due to

Other Conditions Cerebral thrombosis 2 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, industrial place, etc.)
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 2030 Wilkens Ave. Date signed 10/19/48 M. D.

106 K

VS 150

667807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 667807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 W. Melrose Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 W. Melrose Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lou Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband William Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar 12th 1874

8. AGE: Years 69 | Months 7 | Days 5 | If less than one day: hr. min.

9. Birthplace Greenfield, Ind.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Tague
13. Birthplace Ind.

MOTHER
14. Maiden Name Mary A. Frost
15. Birthplace Ind.

16 (a) Informant Mrs. Pannill Martin
(b) Address 4 W. Melrose Ave.

17 (a) Removal (~~Burial, cremation, or~~ removal) **(b) Date thereof** 10/20/48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Park
Location Greenfield, Ind.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) OCT 20 1948 (Date rec'd by Registrar) Huntington - Wilmore M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7th 1946, to Oct 17 1948, and that I last saw h[illegible] alive on 9/23 1948

Immediate cause of death acute Coronary Thrombosis — **Duration** 4 hours

Due to —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 705 Med Arts Date signed M. D. 10/19/48

VS 150

67808 2-46761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55c

Registered No. 67808

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 E other Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Blum

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-75

8. AGE: Years	Months	Days	If less than one day
73	7	3	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Distillery
11. Industry or business

FATHER
12. Name Joseph Blum
13. Birthplace Md

MOTHER
14. Maiden Name Mary Riley
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Parkville Balto Co Md

18 (a) Funeral director Wm Cook Inc
(b) Address 121 S Paca St

19 (a) OCT 20 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1948 at 11:30 a M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1948 to Oct. 19 1948 and that I last saw him alive on Oct. 19 1948

Immediate cause of death: Asphyxia — Duration: 3 Minutes

Due to: Mixo-Fibro Sarcoma of Thyroid Gland — 5 years

Due to:

Other Conditions: Arteriosclerosis Generalized — Years

(Include pregnancy within three months of death)

Date of operation Oct 2nd 1948

Major findings of operation: Mixo-Fibro-Sarcoma of Thyroid

Autopsy: None Allowed.

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert C. Wood M.D.
Address Johns Hopkins Hosp Date signed Oct 19

VS 183

7809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 6578[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Madison
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Chesapeake Ave
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME William D. Neal, Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Neal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-9-90

8. AGE: Years 58 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Garage attendant

11. Industry or business Gasoline sales

FATHER
12. Name John W Neal
13. Birthplace Va.

MOTHER
14. Maiden Name Florence Bennett
15 Birthplace Md

16 (a) Informant Wife
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20-1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Pott & B. M. Walker
(b) Address Park & Eutaw Sts

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14 1948, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10-1948 to 10-18 1948, and that I last saw h[illegible] alive on 10-1[illegible] 1948.

Immediate cause of death Cardiac failure — Duration

Due to Myocardial infarction

Due to Coronary thrombosis — 8 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allyn F. Indot M. D.
Address Mercy Hospital Date signed 10-19-48

X

67810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

67810 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 628 W. Hamburg Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 W. Hamburg Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Campbell

3 (b) If veteran, name war ------

3 (c) Social Security Account No. ------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Fred Campbell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/15/1911

8. AGE: Years	Months	Days	If less than one day
36 37	10	1	hr. min.

9. Birthplace Chester S.C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Thomas Hardy
13. Birthplace S.C.

MOTHER 14. Maiden Name Lizzy Archer
15. Birthplace S.C.

16 (a) Informant Maggie Neely
(b) Address 628 W. Hamburg Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Ct.
Location A.A.Co., Md.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W. Montgomery Street

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williamsburg, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1948 at 3-30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1948, to Oct 16 1948, and that I last saw h[illegible] alive on Oct 16 1948.

Immediate cause of death Cerebral Hemmitage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius L. White M. D.
Address 1602 Pennsylvania Ave Date signed 10-15-48

VS 150

67811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 67811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital ~~or Institution~~ St. Joseph's 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4308 Hamilton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE DOBERER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Irene Virginia Doberer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1881

8. AGE: Years 67 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Florist

11. Industry or business Own Business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Louise List
15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. George L. Doberer
(b) Address 4308 E. Hamilton Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18, 1948, at 5 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4, 1948 to Oct. 18, 1948 and that I last saw h im alive on Oct. 16, 1948.

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to ARTERIOSCLEROSIS, GENERALIZED

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Frank W. Baker, Jr.
Address St Joseph's Hospital signed 10-18-48

VS 150

67812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

✓ 67812 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 742 Edgewood St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 742 Edgewood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Julian H. Jacobs

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Mary R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar 25th 1878

8. AGE: Years	Months	Days	If less than one day
70	6	23	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Grocery Merchant
11. Industry or business Work Self

FATHER
12. Name Unknown
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Mrs. Mary R. Jacobs
(b) Address 742 Edgewood St.

17 (a) Burial (b) Date thereof 10/21/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Mt. Rollins St.

OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18th 1948 at 10 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1948 to Oct 18 1948, and that I last saw him alive on Oct 18 1948.

Immediate cause of death Chronic cardio renal disease — Duration 5 yrs.
Due to
Due to
Other Conditions Cirrhosis Liver
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chas T. Kahle M.D.
Address 1731 Bolton St Date signed 10/19/48

VS 150

121a

667813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

667813 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 S. Luzern Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 806 S. Luzern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia Kowalewska

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Frank Kowalewski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25/97

8. AGE: Years	Months	Days	If less than one day
51	6 7	23	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Kolebuk
13. Birthplace Poland

MOTHER
14. Maiden Name M. Ochal
15. Birthplace Poland

16 (a) Informant Frank Kowalewski
(b) Address 806 S. Luzern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave.

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1948, at 1145 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1948 to Oct. 17 1948 and that I last saw h. alive on Oct 17 1948.

Immediate cause of death: Cerebral hemorrhage (right hemiplegia)
Due to
Due to
Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
sud hours
years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Raymond R. Nowak M. D.
Address 408 S. Patt. Pk. Ave. Date signed 10/19/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information supplied on this certificate is officially supplied.

67814 ✓ 67814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2312 Cambridge St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 Cambridge St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walenty Stasiak
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Stanislawa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2/1875

8. AGE: Years	Months	Days	If less than one day
73.	8	16	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Frank Stasiak
13. Birthplace Poland

MOTHER
14. Maiden Name Bakiona
15. Birthplace Poland

16 (a) Informant Marian Stasiak
(b) Address 344 Susquahanna Ave.

17 (a) Burial (b) Date thereof Oct. 21/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarzenski
(b) Address 1930 Eastern Ave.

19 OCT 20 1948 (b) Huntington Nottingham, M.D.
(Date filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 1948 at 3:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1948 to Oct 18 1948.
and that I last saw him alive on Oct 17 1948.

Immediate cause of death Coronary thrombosis
Antecedent pneumonia
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
5d.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. L. Lepley M. D.
Address 6 W. Fayette St. Date signed 10/19/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

67815

AB-122050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. 67815

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 39yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 North Maderia St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Strother

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19- 1884 *

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57,	3	25	18	41

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name John Strother
13. Birthplace Va.

MOTHER
14. Maiden Name Mandy ?
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave

17 (a) Burial (b) Date thereof oct. 20-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Leroy O. Wilson
(b) Address 1005 Blanty ave

19 OCT 20 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14- 1948 at 10.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12- 1948 to 10-14 1948, and that I last saw him alive on 10-14- 1948

Immediate cause of death Respiration type Pneumonia

Due to Carcinoma of esophagus with Gastroesophageal fistula

Due to Trachea Fistula

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/1942 + 10/14/48

Major findings of operation: Normal anatomy

of autopsy: Carcinoma of esophagus Gastric fistula and Empyema Pneumonia

Duration: 4 days ? ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place? in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman J. Cole M.D. M.D.
Address 4940 Eastern Ave Date signed 10/14/48

vs 150 * Stepdaughter-Irene Robinson gave information correct age is 57- X

67816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

Registered No. 67816

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 S. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olaf Andersen

3 (b) If veteran, name war: ---

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Hazel Andersen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1905

8. AGE: Years	Months	Days	If less than one day
43	0	26	hr. min.

9. Birthplace: Norway (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: --- Andersen
13. Birthplace: Norway

MOTHER
14. Maiden Name: -----
15. Birthplace: Norway

16 (a) Informant: Mrs. Hazel Andersen
(b) Address: 2032 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22/48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem
Location: Balto. Md.

18 (a) Funeral director: Philip Herwig Sons
(b) Address: 2024 Orleans St.

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18/48 19..., at 3:40 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertrophy and dilatation of heart
Edema of lungs.
Fatty degeneration of liver

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 10/19/48

G6781?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

✓ G6781? Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4009 Evans Chapel Road
(c) Hospital or institution: Union Memorial Hospital (DOA)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4009 Evans Chapel Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Herbert Davis

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-3720

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife H. Elwood Paxton

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1885

8. AGE: Years 63 | Months 8 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer, Retired

11. Industry or business Roland Park Co.

FATHER
12. Name Richard Davis
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ellen French
15. Birthplace Md.

16 (a) Informant Mrs. Treva D. Martin
(b) Address 1105 Buckley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21, 1948 (month) (day) (year)
(c) Cemetery or crematory Moreland Park.
Location Taylor Ave.

18 (a) Funeral director Paul E. Benneville
(b) Address 3615-17 Chestnut Ave.

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Oct. 1948; at 11:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D. Medical Examiner.
Date signed 18 Oct. 48

VS 151

67818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ 67818 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 13 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days). 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 W. 34th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Leroy Johnson

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 717-07-7967

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ruth Virginia Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1903

8. AGE: Years 45 | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Co., Maryland (Town, county, and state)

10. Usual Occupation Crew Caller

11. Industry or business Pennsylvania Railroad

FATHER
12. Name Harry M. Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Louella Hedrick
15. Birthplace Maryland

16 (a) Informant Mrs. Ruth V. Johnson
(b) Address 715 W. 34th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co., Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) OCT 20 1948 (b) Huntington Williams, M.D.
(Registrar's signature)

VS 151

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH October 18, 1948 at 4:40 M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include conditions within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 10/18/48

X

67819

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. 66281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 334 CALVERT ST.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTIMORE
6 City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 W. 34th ST. B
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY DAVIS TALBOTT

3 (b) If veteran, name war Navy
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife MRS Mary L. Talbott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 7, 1888

8. AGE: Years 60 | Months 4 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace MARYLAND - West River
(Town, county, and state)

10. Usual Occupation POLICEMAN - Park

11. Industry or business

FATHER 12. Name WILLIAM TALBOTT
13. Birthplace MARYLAND

MOTHER 14. Maiden Name ANNIE McMAHON
15. Birthplace PA

16 (a) Informant HENRY DAVIS TALBOTT.
(b) Address 927 W. 34th ST. BALT. 11, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20-1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 17 1948, at 9:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT 8 1948, to OCT 17 1948, and that I last saw h[illegible] alive on OCT 17 1948

Immediate cause of death CORONARY INSUFFICIANCY. — Duration

Due to CORONARY ARTERY DISEASE

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature William E. Beaven. M. D.
Address Union Mem. Hosp. Date signed 10-17-48

X

67820

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 921

Registration No. 16345

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3206 Liberty Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM G. WELLER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	no	male	white	married

6 (b) Name of husband or wife Mary W. Weller nee Weltner
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 31, 1867

8. AGE: Years	Months	Days	If less than one day
81	8	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. H. J. Van Voorem
(b) Address 3206 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director [illegible] I. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19, 1948, at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to 10-18 1948 and that I last saw h[illegible] alive on 10/18 1948.

Immediate cause of death Arteriosclerotic Heart Disease — Duration ?

Due to Arteriosclerosis

Due to

Other Conditions Chronic Bronchitis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin L. Lineweaver
Address 1109 St Paul St Date signed 10/19/48

Martin L. Lineweaver

VS 150

667821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667821

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 E. 23rd St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 E. 23rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilson Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	Col.	Widower

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1888

8. AGE: Years	Months	Days	If less than one day
60	4	1	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Gardner
11. Industry or business

FATHER
12. Name Basil Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Olivia
15. Birthplace Md.

16 (a) Informant Maggie Cole
(b) Address 31 E. 23rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20/48 (month) (day) (year)
(c) Cemetery or crematory St. Stephens Am.
Location Essex Md.

18 (a) Funeral director Mrs Dott G. Elliott & Dgt
(b) Address 1129 N. Carlin's St.

19 (a) OCT 20 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17, 1948 at 11 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1948 to Oct 17 1948 and that I last saw h alive on Oct 17 1948.

Immediate cause of death Uremic Coma

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
4 da.

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, industrial place, etc.)
(e) Means of injury

23. Signature Rose A. Jackson
Address 2029 Guilford Ave Date signed Oct 19, 1948

X

67822

LCH-183776

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a

Registered No. 67822

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Burr Way
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS COOPER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/8/48

8. AGE: Years	Months	Days	If less than one day
	3	7 9	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Gregory
13. Birthplace ?

MOTHER
14. Maiden Name Jean Cooper
15. Birthplace N.Y.

16 (a) Informant: Balto. City Hosp. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 10-20-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Reinhardt Ave.

19 (a) OCT 20 1948 (b) Huntington Williamson, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17/48 19 at 2:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15/48 19 to 10/17/48 19 and that I last saw him alive on 10/17/48 19

Immediate cause of death	Duration
Chronic malnutrition — duration indeterminate - prob. years	
Due to Coarse mucous - aspirated poor home care	
Due to	
Other Conditions Enteritis (organism not known yet)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William P. Kean M. D.
Address Baltimore City Hosp. Date signed 10-19-48

154

678823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

678823
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3703 Chatham Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 Chatham Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Gellman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1886

8. AGE: Years 62 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Produce Business

11. Industry or business

FATHER
12. Name Charles
13. Birthplace Russia

MOTHER
14. Maiden Name Jessie
15. Birthplace Russia

16 (a) Informant Anna Gellman
(b) Address 3703 Chatham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-48 (month) (day) (year)
(c) Cemetery or crematory Sharre Tefloh
Location Windsor Mill Road

18 (a) Funeral director Jack Levin Inc
(b) Address 240 Eutaw Place

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20-1948 at 1:4 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/1 1947 to 10/20 1948, and that I last saw h / M alive on 10/20 1948

Immediate cause of death: Coronary occlusion — Duration: 1/2 hr.

Due to Generalized arteriosclerosis — 12 yrs

Due to

Other Conditions Previous coronary occlusion — 10 yrs ago
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Feldman Jr
Address 817 St Paul St Date signed 10/20/48 M.D.

VS 150

X

667824

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92

667824
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 937 Park Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 937 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA B. THOMPSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Married

6 (b) Name of husband or wife John Henry Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1893

8. AGE: Years	Months	Days	If less than one day
55	5	13 14	hr. min.

9. Birthplace Moncure, N.C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Albis Bynum
13. Birthplace N.C.

MOTHER
14. Maiden Name Betty Bynum
15. Birthplace N.C.

16 (a) Informant Rosa B. Thompson
(b) Address 937 Park Avenue

17 (a) Burial (b) Date thereof 10/22/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus, Md.

18 (a) Funeral director CHAS. R. Law
(b) Address 802 Madison Avenue-1

OCT 20 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1948 at 1.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1948 to 10-15 1948.
and that I last saw h alive on 10-18 1948

Immediate cause of death Cerebral Hemorrhage — Duration 9

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles F. Wood M. D.
Address 361 Cleveland Ave Date signed 10-19-48

VS 153

G67825

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. G67[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2130 N. Howard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2130 N. Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Gunthrope

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Lula Gunthrope
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1897

8. AGE: Years	Months	Days	If less than one day
51	4	22	hr. min.

9. Birthplace Great Falls S.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thadeous Gunthrope
13. Birthplace Great Falls S.C.

MOTHER
14. Maiden Name Fannie
15 Birthplace Great Falls S.C.

16 (a) Informant Howard Foster
(b) Address 2130 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20, 1948. (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) OCT 20 1948 (b) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 - 1948 at [illegible] M

21. I certify that death occurred on the date above stated that I attended deceased from Oct 10 1948 to Oct 16 1948.
and that I last saw h alive on 19
Immediate cause of death Cardio Renal Disease

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
1 Yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2329 Jeffords St Date signed

VS 153

G67826

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 55E

Registered No. G67826

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 25-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3722 Giles Road 2722 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELLA WHITE

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 24, 1896

8. AGE: Years	Months	Days	If less than one day
51	9	25	hr. min.

9. Birthplace Rock Hill, South Carolina (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Woodie McCright
13. Birthplace Rock Hill, South Carolina

MOTHER
14. Maiden Name Jennie
15. Birthplace Rock Hill, South Carolina

16 (a) Informant John S. White (son)
(b) Address 2722 Giles Road (Cherry Hill)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore city

18 (a) Funeral director Joseph A Lewis
(b) Address 6 Hartsdale at Huntington Williams, MD

19 (a) Oct 20 1948 (Date received by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 19 48 at 7:30 PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of Abdomen

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Royer Medical Examiner M.D.
Date signed 10-20-48

VS 151

G67827

BALTIMORE CITY HEALTH DEPARTMENT ✓ G67827
Registered No.

CERTIFICATE OF DEATH 10 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 S. Port Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Czajkowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Serafina
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Feb 23 1887

8. AGE: Years	Months	Days	If less than one day
61	7	23	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Konstanty Czajkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Adamczyk
15. Birthplace Poland Czyk

16 (a) Informant Mrs Serafina Czajkowski
(b) Address 807 S. Port Street

17 (a) Burial (b) Date thereof 10-22-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Balto County

18 (a) Funeral director John J. Welbes
(b) Address 401 S. Chester Street

19 OCT 20 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18 1948, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1948, to 10-18 1948, and that I last saw him alive on 10-18 1948.

Immediate cause of death	Duration
massive Pulmonary Infarct	
Due to thrombophlebitis of leg	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy massive infarct - lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roger Sokol M. D.
Address Sinai Hosp - Balt. Date signed 10-18-48

VS 150

Physicians: please write the causes of death clearly and legibly. Especially important.

SC-48-2398 ✓ 667828

667828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. 667828

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1076 Granby St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Joseph Brashears ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-3-48

8. AGE: Years	Months	Days	If less than one day
0	0	16	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation infant
11. Industry or business

FATHER
12. Name Joseph Brashears
13. Birthplace Balto Md

MOTHER
14. Maiden Name Betty Deiner
15 Birthplace W. Va.

16 (a) Informant Father
(b) Address

17 (a) Burial (b) Date thereof 10/20/1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern ave. Road
18 (a) Funeral director Wendell Dippel
(b) Address 312 S. Highland Ave
19 (a) Date received by Registrar 10-20-1948 (b) Registrar Covington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19-1948, at 12:09 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17-1948 to 10-19-1948, and that I last saw him alive on 10-19-1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Extreme dehydration	2-3 days
Due to Diarrhea, infant of unknown etiology	10 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury
23. Signature Calvin P. Jordan M. D.
Address Mercy Hospital Date signed 10-19-48

667829 ✓ 667829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 944 N. Castle St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Charles N. Wiseman

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-07-2792
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Margaret A.
6 (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) 9-26-89
8. AGE: Years 59 Months 6 Days 23 If less than one day ..... hr. ..... min.
9. Birthplace Baltimore (Town, county and state)
10. Usual Occupation Shipfitter
11. Industry or business Beth. Steel Co.

FATHER
12. Name John Wiseman
13. Birthplace Balto.

MOTHER
14. Maiden Name Elizabeth Miller
15. Birthplace Balto.

16 (a) Informant Margaret A. Wiseman
(b) Address 944 N. Castel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4600 Belair Rd.

18 (a) Funeral director Riggle Bros.
(b) Address 1800 E. Lombard St

19 (a) Oct 20 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1948 at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17-1948 to 10-19-1948, and that I last saw him alive on 10-18-1948

Immediate cause of death: Bronchopneumonia — Duration 2 days

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: Purulent Pericarditis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Joseph V. Brady M. D.
Address Md Gen Hosp Date signed 10-19-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G67830

ES-123733

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 133

G678.50

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 EASTERN AVE.

(c) Hospital or institution: BALTO. CITY HOSPITALS 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.

(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 827 N. Eutaw St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret F. Klunk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife William ROLAND

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-17-09

8. AGE: Years	Months	Days	If less than one day
38	11	2	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER

12. Name James Birmingham (D)

13. Birthplace Va.

MOTHER

14. Maiden Name Nancy Wynne (D)

15. Birthplace Va.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS

(b) Address 4940 EASTERN AVE.

17 (a) Burial (b) Date thereof 10/22/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1900 Eutaw Place

19 (a) Oct 20 1948 (b)
(Date received by Registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19 19 48, at 3:20 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-13 19 48, to 10-19 48 and that I last saw her alive on 10-19 19 48

Immediate cause of death

Duration

(a) Advanced pulmonary tuberculosis	3 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Dr. C.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Margaret A. Morgan M. D.

Address Baltimore City Hosp Date signed 10-21-48

X

G67831 ✓ G67831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. .....

1. PLACE OF DEATH: Provident Hosp.
(a) Baltimore City, Maryland Balto. Md.
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 618 Archer St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME William E. Pinkney

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) Oct. 13, 1904

8. AGE: Years	Months	Days	If less than one day
44 yr.		4	hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Pinkney
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Lnella
15. Birthplace Baltimore, Md.

16 (a) Informant Esther Barnes
(b) Address 618 Archer St.

17 (a) Burial (b) Date thereof Oct 21 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto Md

18 (a) Funeral director Isaiah L Pinn Sons
(b) Address 1640 Montgomery St

OCT 20 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1948 at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2-48 1948 to 10-17 1948 and that I last saw him alive on 10-17 1948

Immediate cause of death Renal failure

Duration

Due to Malignant phase of Chronic glomerulonephritis

Due to .....

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury S.E. Broadnax M.D.

23. Signature S.E. Broadnax M.D.
Address Provident Hosp. Date signed 10-20-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667832 — 93 — Registered No. 667832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3218 Keswick Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hr
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3218 Keswick Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah C Frazier

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Harry, S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5 - 1873

8. AGE: Years 75 | Months | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Niles

13. Birthplace Conn.

MOTHER 14. Maiden Name unknown

15. Birthplace Md

16 (a) Informant Mrs Catherine L Lang

(b) Address 3218 Keswick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-48 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Baltimore

18 (a) Funeral director Frank H Zeh

(b) Address 814 N 36th St.

19 (a) (b) Registrar Huntington Williams

OCT 20 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1948, at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10, 1948 to Oct 19 1948
and that I last saw h alive on Oct 18 1948

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	10 years
Due to Myocardial Arteriosclerosis	10 years
Due to Senility	10 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Wallenstein M. D.

Address 848 W 36 St Date signed 10/19/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G678.53

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

Registered No. G678.53

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Morris St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marissa Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-25-85

8. AGE: Years 62 | Months 10 | Days 24 | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name James Edwards

13. Birthplace Va

MOTHER 14. Maiden Name Mirah Jones

15. Birthplace Va

16 (a) Informant JOHNS HOPKINS HOSPITAL Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Fort Wayne Ind.

18 (a) Funeral director Charles H. Alexander

(b) Address 1200 Mccullah St, Baltimore, Md.

OCT 20 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Oct 19 1948 at 10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-4-1948 to 10-19-1948 and that I last saw h alive on 10-19-1948

Immediate cause of death Anemia — Duration

Due to Carcinoma of Bladder

Due to

Other Conditions Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. C. Andrews M. D.

Address Johns Hopkins Hosp Date signed 10-20-48

VS 159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 66548

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: MARYLAND GENERAL HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Orkney Rd #12 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country.

3 (a) FULL NAME BABY BOY HALVERSON

3 (b) If veteran, name war: NO —

3 (c) Social Security Account No.: NONE

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife: NONE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): OCT 11, 1948

8. AGE: Years — | Months — | Days 3 | If less than one day hr. min.

9. Birthplace: BALTIMORE, MD (Town, county, and state)

10. Usual Occupation: INFANT

11. Industry or business —

FATHER 12. Name: WILLIAM P. PEARSON
13. Birthplace: MARYLAND

MOTHER 14. Maiden Name: MAXINE HALVERSON
15. Birthplace: WISCONSIN

16 (a) Informant: MAXINE HALVERSON
(b) Address: 512 ORKNEY ROAD BALTIMORE 12, MD

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Johns Hopkins Medical School OCT 18 1948

18 (a) Funeral director: Commissioner of Health
(b) Address

19 (a) OCT 20 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 OCT 1948 at 9:55 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11 OCT 1948 to 14 OCT 1948, and that I last saw h/M alive on 14 OCT 1948.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	2 HOURS
Due to PREMATURITY (30 WEEKS GESTATION)	3 DAYS
Due to WEIGHT OF BODY - 1050 GMS	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: PREMATURITY

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Donald F. England M. D.
Address: MARYLAND GEN. HOSP. Date signed: 15 OCT 48

VS 189

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57E

Registered No. 46518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette and John Sts.
(c) Hospital or institution: Hospital for the women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 939 Stiel St (Rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Boy Bloom

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/16/48

8. AGE: Years	Months	Days	If less than one day
		2	hr min.

9. Birthplace Baltimore 17 Maryland. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Howard William Bloom
13. Birthplace Altoona, Pa.

MOTHER
14. Maiden Name Julia McLamb
15. Birthplace Vincent North Carolina

16 (a) Informant Mrs Howard Bloom
(b) Address 939 Stiel St, Brooklyn Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10 19 48 (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School
Location OCT 19 1948
Commissioner of Health

18 (a) Funeral director —
(b) Address —

19 (a) OCT 20 1948 (Date rec'd by Registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1948 at 2 10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 16 1948 to Oct 18 1948, and that I last saw him alive on Oct 18 1948.

Immediate cause of death	Duration
Cardiac Failure.	
Due to Congenital Heart Disease.	
Due to Absent Interauricular Septum; Failure of Rotation Heart and great vessels.	
Other conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vernon C. Kelly, M D
Address Woman's Hospital Date signed 10-19-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

78:56 48-22079

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. 6678.56

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2721 N. Charles St.
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1260 E. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Wilmering

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/12/48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Bernard Wilmering
13. Birthplace Germany

MOTHER
14. Maiden Name Ineas Snyder
15. Birthplace Birmingham - Alabama

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School OCT 19 1948
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) OCT 20 1948 (b) Huntington Williamsport, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13/48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12/48 19 to 10/13/48 19 ; and that I last saw him alive on 10/13/48 19

Immediate cause of death (a) Respiratory Failure — Duration
Due to (b) Prematurity
Due to (c)
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address 2428 S. Highland Ave. Date signed 10/13/48

6678.57

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 307

6678.57
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1538 N. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JESSE O. HEADLEY

3 (b) If veteran, name war None

3 (c) Social Security Account No. 717-17-7255

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Myrtle B. Headley
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) June 24, 1897

8. AGE: Years	Months	Days	If less than one day: hr.	min.
51	3	24		

9. Birthplace Frederick Co. Va. (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Penn. R.R.

FATHER
12. Name William C. Headley
13. Birthplace Frederick Co. Va.

MOTHER
14. Maiden Name Nora Jane Rudolph
15. Birthplace Shanadoah Co., Va.

16 (a) Informant: Myrtle B. Headley
(b) Address 1538 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/21/48 (month) (day) (year)
(c) Cemetery or crematory Lebnon Cemetery
Location Lebnon, Va.

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

19 (a) 20 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 19 48, at 6:45 PM

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage Spontaneous
Antecedent Hypertension
Due to Uremic Retinitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royston M.D. (Medical Examiner)
Date signed 10-19-48

678838

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

678838 Registered No.

63B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Oxford (If outside city or town limits, write RURAL and give town)
(d) Street No. R. F. D # 3 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Emmett James Patrick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Emmett James Patrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27 1898

8. AGE: Years	Months	Days	If less than one day
50	6 4	7 2 4	hr. min.

9. Birthplace Tennessee (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Andy Hayworth
13. Birthplace North Carolina

MOTHER
14. Maiden Name Lilly Simcox
15 Birthplace Tennessee

16 (a) Informant James Patrick
(b) Address Oxford Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23 1948 (month) (day) (year)
(c) Cemetery or ~~crematory~~ West Nottingham
Location Colora, Md.

18 (a) Funeral director J. E. Tyson
(b) Address Rising Sun Md.

19 (a) OCT 21 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1948, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1948 to Oct 20 1948, and that I last saw her alive on Oct 20 1948.

	Duration
Immediate cause of death Coronary Occlusion	
Due to Coronary Artery Disease ?	
Due to	
Other Conditions Toxic Thyroidism Menopause. (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mortimer Lee Williams M. D.
Address Union Memorial Hosp. Date signed 10-20-48

94a

VS 193

667839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 877

Registered No. 667839

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: God Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Vokes J. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia B. Gilroy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 7th 1856

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	0	13		

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name James Gilroy
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Cain
15 Birthplace Md.

16 (a) Informant Mrs. Loretta McGregor
(b) Address 812 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 21 1945 (Registrar's date) (b) Kensington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20th 1945 at 6a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1945 to Oct 18 1945 and that I last saw h[illegible] alive on Oct 18 1945.

Immediate cause of death Acute Myocarditis

Due to Multiple Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
hours
Months

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, etc.)
(e) Means of injury

23. Signature Thos. F. Gorman M.D.
Address 1012 Edmondson Ave. Date signed 10/29/45

VS 150

G678-0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G678-0 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3436 Elm Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3436 Elm Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan E. (Parks) Parks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife William (Parks) Parks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5th 1858

8. AGE: Years	Months	Days	If less than one day
84	810	15	hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Henry Ruby.
13. Birthplace Md.

MOTHER 14. Maiden Name Olevia Cox
15 Birthplace Md.

16 (a) Informant Mrs Trout
(b) Address 2423 Maisel Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Jr.
(b) Address 1217 St. Paul St.

19 (a) OCT 21 1948 (Date received by registrar) (b) Thurlington Williamson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20th 1948, at 3 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1948 to Oct 20 1948. and that I last saw h[illegible] alive on Oct 19 1948.

Immediate cause of death Cong. Heart Failure — Duration
Arteriosclerosis
C.V. Dis.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin B. Hassman M. D.
Address 4031 Falls Rd Date signed 10/20/48

VS 199

G6784-1

ES-123838

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124a

G6784-1 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Hillman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Long

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-18-6437

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1883

8. AGE: Years	Months	Days	If less than one day
65	4	5	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Deceased Long
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Deceased
15. Birthplace Balto. Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITAL S
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

19 OCT 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20- 19 48 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 19 48 to 10-20 19 48 and that I last saw h im alive on 10-20 19 48

Immediate cause of death Leannecis Carbonis — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As Above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Vickers M. D.
Address Balto City Hosp. Date signed 20 Oct 48.

VS 150

G6784-2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G6784-2

Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William R. Dunphy

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Emma K. Dunphy
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) May 13 1876

8. AGE: Years	Months	Days	If less than one day
72	2	5	hr. min.

9. Birthplace Towson Md. (Town, county, and state)
10. Usual Occupation Paper Hanger
11. Industry or business Self

FATHER
12. Name Wm S. Dunphy
13. Birthplace Texas Md.

MOTHER
14. Maiden Name Matilda Goodwin
15 Birthplace Balto. Co. Md.

16 (a) Informant Mrs. Emma Dunphy
(b) Address 1216 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 417 St. Paul St.

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1948, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1948 to Oct 18 1948 and that I last saw h alive on Oct 17 1948

Immediate cause of death Coma — Duration 24 hours
Due to Cardio Renal — 4 yrs
Due to arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Donovan
Address 3136 Keswick Rd Date signed Oct 27 1948

67843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 67843

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St
(c) Hospital or institution:
Good Samaritan Nursing Home 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1336 W Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 25 1874

8. AGE: Years 73 | Months 10 | Days 24 21 | If less than one day hr. min.

9. Birthplace Frederick Co Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Dept Public Welfare Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/21/48 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem
Location Bal Co.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St Huntington Publishing Co, Md

19 (a) OCT 21 1948 (Date rec'd by registrar) **(b)** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1948 at 5 55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1948 to Oct 15 1948 and that I last saw him alive on Oct 13 1948.

	Duration
Immediate cause of death Arteriosclerotic Cardiovascular Disease	?
Due to	
Due to	
Other Conditions Pres. Pul. Tbc	?

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Carl P Roeding M. D.
Address 1316 W Lombard St Date signed 10/20/48

VS 150

G6784 Dr. Traugott.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

Registered No. 16784

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2313 Greenmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2313 Greenmount Avenue
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUSIE TAWNEY

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1873

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Mannion
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret (34
15. Birthplace Ireland

16 (a) Informant Mrs. Emmerick
(b) Address 2313 Greenmount Ave

17 (a) Burial (b) Date thereof 10/23/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22nd ST.

19 (a) Oct 21 1948 (b) by [illegible] Contractor Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20/48 19 , at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1947 to Octo 20 1948.
and that I last saw h er alive on Octo 14 48

Immediate cause of death Coronary thrombosis. — Duration 2

Due to arteriosclerosis

Due to

Other Conditions arteriosclerotic decomp.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Karl Traugott M.D.
Address 1623 E. N. Ave. Date signed 10/20/48

VS 150

G67845

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52a

Registered No. G67845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4308 Forest Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4308 Forest Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Solomon Berg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Yetta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Real Estate
11. Industry or business

FATHER
12. Name Pusey
13. Birthplace Russia

MOTHER
14. Maiden Name Libby
15. Birthplace Russia

16 (a) Informant Yetta Berg
(b) Address 4308 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1100 Eutaw Place

19 (a) OCT 21 1948 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20 19 48 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 48 to Oct 20 19 48 and that I last saw h alive on Oct 18 19 48

Immediate cause of death	Duration
Hypernephroma Left Kidney	17 mos
Due to Metastasis to Lung	6 mos
Due to Pulmonary Metastasis	6 mos
Other Conditions Malignant Neoplasm Prostate	6 mos

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A A Weinstock M. D.
Address 4003 E Baltimore Date signed 10/21/48

VS 150

16786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 16786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Woodington Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) N-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County C
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Woodington Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry J. Keasmeier Sr

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Anna B. Keasmeier

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) April 2 1872

8. AGE: Years 76 | Months 6 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Feed Merchant

11. Industry or business

FATHER
12. Name Henry Keasmeier
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Horseman
15. Birthplace Germany

16 (a) Informant Catherine M. Knodt
(b) Address 700 Woodington Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22, 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn A.A. Co.

18 (a) Funeral director Mr. & Mrs. John W. Teufel & Son
(b) Address 5311 Edmondson Ave.

19 (a) Registrar (b) Huntington Williamsport

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1948 at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1948 to Oct 19 1948.
and that I last saw h alive on Oct 19 1948.

Immediate cause of death: Coronary Thrombosis — Duration 6 hrs.
Due to
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ernest H. Kline M. D.
Address 1730 Poplar Gr Ave Date signed 10/20/48

Please answer all questions carefully and legibly. Physicians: please write the causes of death clearly and legibly.

BC 48-20305 G6678 G6678:7

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 8 0 B

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens ave
(c) Hospital or institution:
St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Wade ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Carroll Johnson.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9 1945

8. AGE: Years	Months	Days	If less than one day: hr	min
3 1/2	7	10		

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Nathan Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Evelyn Gunther.
15. Birthplace Md.

16 (a) Informant Mr. Nathan Johnson
(b) Address Wade Ave - Catonsville Md Detroit Mich

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3800 Old Frederick Rd

18 (a) Funeral director Henry A. Wirtz
(b) Address 401 E. Lanvale St

19 (a) OCT 21 1948 (Date received by registrar) (b) Curtis Bay Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 19 1948 at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16/1948 to 10/20/1948 and that I last saw her alive on 10/20 1948

Immediate cause of death CARDIO - RESPIRATORY FAILURE — Duration

Due to ENCEPHALITIS

Due to CEREBRAL EDEMA (MORTIS)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John. W. Williams M. D.
Address St. Agnes Hosp. Date signed 10/20/48

VS 150

67848 ES-105645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

Registered No. 67848

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS 20-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Walbrook ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Schubert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Sep. Widowed

6 (b) Name of husband or wife Late Louise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 24, 1881

8. AGE: Years	Months	Days	If less than one day
66	9	2526	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Christian Schubert
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Schwartz
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North ave + Hary St.

18 (a) Funeral director Harry H. Kutzke
(b) Address 410 Edmondson ave

19 (a) [illegible] (b) Huntington Williams, M.D. (Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19 1948, at 2:00 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-29 1946 to 10-19 1948, and that I last saw him alive on 10-19 1948

Immediate cause of death Bilat. Far advanced Pulmonary Tuberculosis — Duration 2 8 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address Balto. City Hosp. Date signed Oct 19-48

VS 150

G67843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160c

G67843 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 St. Helena Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Vesley

3 (b) if veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10·15·48

8. AGE: Years	Months	Days	If less than one day
—	—	—	3 hr. 30 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Louis J. Vesley
13. Birthplace Essex, Maryland

MOTHER
14. Maiden Name Dorothy Sheppard
15. Birthplace North Carolina

16 (a) Informant Baltimore City Hospitals-records and Dorothy Vesley
(b) Address 229 St Helena AVE, Md

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 10-18-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) OCT 21 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10·15·48 at 12 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10·15·48 to 10·15·48 and that I last saw h in alive on 10·15·48

Immediate cause of death	Duration
Prematurity	
Due to Premature separation of placenta	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clyde H Titus MD
M D
Address 4940 Eastern Ave Date signed 10-15-48

VS 150

667850 BC-48-23 AB-123788

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

667850 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Morton-Twin A.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 16-1948

8. AGE: Years	Months	Days	If less than one day
			5 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander Moore
13. Birthplace Md.

MOTHER
14. Maiden Name Ruth Morton
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 10-19-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave

18 (a) Funeral director
(b) Address

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Huntington-Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October- 16 1948, at 1.03 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16- 1948 to 10-16- 1948, and that I last saw him alive on 10-16- 1948.

Immediate cause of death Premature

Duration 5 hr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William P. Kean M. D.
Address Baltimore City Hosp. Date signed 10-19-48

G678:51

JL - 123798

BC 123490

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. G678:51

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 E. Madison Ste
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Morton -"B" - Ruth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1948

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander Moor
13. Birthplace Md.

MOTHER
14. Maiden Name Ruth Morton
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 10-19-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave

18 (a) Funeral director
(b) Address

19 (a) OCT 21 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1948, at 2.20 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1948, to Oct. 17 1948. and that I last saw him alive on Oct. 17, 1948

Immediate cause of death Premature

Duration 1 da.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury.

23. Signature William P. Kean M. D.
Address Balto City Hosp Date signed 10-19-48

VS 150

G67852

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

167

Registered No. G67852

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 532 Burgundy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROLAND DORSEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 45 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Howard County, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Wesley Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Nellie Gross
15. Birthplace Md.

16 (a) Informant Seymore Fischer
(b) Address 532 Burgundy St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A.R.C. Md.

18 (a) Funeral director Sarah L Brownson
(b) Address 1086 Montgomery St

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1948, at 7.20p M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab Wound of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-11-48 at ? p. M.
(b) Where did injury occur? 532 Burgundy St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Sharp instrument

23. Signature Emil L Rey M.D. (Medical Examiner)
Date signed October 12, 1948

X

667853

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 667853

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2002 Brunt Street
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 Brunt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Widower

6 (b) Name of husband or wife Josephine G. Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/25/'74

8. AGE: Years	Months	Days	If less than one day
73	9	23	25 hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Elizabeth Jackson
(b) Address 2002 Brunt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22, '48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, Md.

18 (a) Funeral director Joseph L. Russ
(b) Address 1200 McCulloh St.

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1948, at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1946 to Oct 19 1948 and that I last saw h alive on May 10 1948.

	Duration
Immediate cause of death Cardio Vascular Disease	2 yr
Due to Hypertension	2 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Frey
Address 1928 Penna Ave Date signed 10/20/48

VS 153

X

G67854

ES- 121536

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47

Registered No. G67854

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 EASTERN AVE.

(c) Hospital or institution: BALTO. CITY HOSPITALS.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 22 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 2527 Penn Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gladys Currie (or Gladys Blake)

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Clarence Currie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 27, 1905

8. AGE: Years	Months	Days	If less than one day
42	10	21	hr. min.

9. Birthplace Va. (Roanoke) (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER

12. Name W. Gordon Blake

13. Birthplace Va.

MOTHER

14. Maiden Name Pearnie Turner

15. Birthplace Va.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS

(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 21 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

P

20. DATE OF DEATH 10-18- 1948 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24 1948 to 10-18- 1948, and that I last saw her alive on 10-18-48 1948

Immediate cause of death: Respiratory failure

Due to: Carcinoma of lung with wide spread metastasis

Duration:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-30-48

Major findings of operation: Biopsy - Carcinoma (metastatic to lymph node)

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. J. Kirwaky

Address Balto. City Hosp. Date signed 10/21/48 M.D.

E. J. Kirwaky X

VS 153

667855

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

74a

Registered No. 66785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address 1622 Chilton St.
(c) Hospital or institution:

9-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 Chilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE BRUNING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Minnie E. Bruning nee Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1871

8. AGE: Years	Months	Days	If less than one day
77	7	26	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Sea Food Dealer
11. Industry or business Self

FATHER
12. Name – Bruning
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Minnie Bruning
(b) Address 1622 Chilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 21 1948 (Date rec'd by registrar) Huntingtown Millington, Md.

VS :50

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18, 1948, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to Oct 17 1948. and that I last saw h[im] alive on Oct 17 1948.

Immediate cause of death Carcinoma

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Denis J. McGrath
Address 1E. Randall St. Date signed 10/18/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45 B

Registered No. 67856

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): Life
(e) Length of stay in Baltimore (yrs., mos., or days): 85 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1304 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: FRANK JOS. MORRIS

3 (b) If veteran, name war: VA I

3 (c) Social Security Account No.: 220-07-[illegible]886

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret Morris

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): Jan. 1, 1891

8. AGE: Years 57 | Months 9 | Days 18 | If less than one day: hr. min.

9. Birthplace: Balto, Md. (Town, county, and state)

10. Usual Occupation: Plumber

11. Industry or business:

FATHER
12. Name: Joseph Morris
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Hunt
15. Birthplace: Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory: New National Cemetery
Location: Frederick Ave. Baltimore, Md.

18 (a) Funeral director: Lilly & Zeiler, Inc
(b) Address: 403 S. Wolfe St. Baltimore, Md.

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Signature of Registrar: Hunter Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 19 1948, at 9:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jul 26 1948 to Oct. 19 1948 and that I last saw him alive on Oct. 19 1948.

	Duration
Immediate cause of death: 1- Carcinoma of tongue with regional metastasis	1 yr
Due to: 2- Jaundice due to intrinsic obstruction of	3 mo.
Due to: common bile duct	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 10/20/48

V S 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6678:7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 6678:7

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 N. Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 N. Carey St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH PARKER

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife JACOB
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/11/1879

8. AGE: Years	Months	Days	If less than one day
68	11	6	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Perry Scott
13. Birthplace Eastern Shore, Md.

MOTHER
14. Maiden Name Mary Turner
15. Birthplace Galena Md.

16 (a) Informant Alberta Nichols (Niece)
(b) Address 425 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery or crematory Olivet Cemetery
Location Galena, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) Filed by registrar OCT 21 1948 (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17th, 1948, at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1948 to Oct 17 1948 and that I last saw her alive on Oct 17 1948

Immediate cause of death: Cerebral Hemorrhage
Duration: 18 hours
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Watts M. D.
Address 512 N. Carrollton Ave Date signed 10-21-48

VS 150

678558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

678558 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 100 N. Calhoun St

(c) Hospital or institution: Franklin Square

(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) /

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No 1837 Wilhelm St (If rural give location)

(e) Citizen of foreign country? (~~Yes or~~ No) If yes, name country

3 (a) FULL NAME Joseph W. Howard

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-07-8715

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mary R. Howard

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) May 18, 1889

8. AGE: Years 59 | Months 5 | Days 1 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business U. S. Steel

FATHER 12. Name George Howard

FATHER 13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Katherine Mitchell

MOTHER 15. Birthplace Balto. Md.

16 (a) Informant Mary R. Howard

(b) Address 1837 Wilhelm St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Frederick Ave.

18 (a) Funeral director Craig Funeral Home

(b) Address 1216 E. Chase St.

19 (a) Oct 21 1948 (Entered by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from October 15 1948 to Oct. 19 1948, and that I last saw him alive on Oct 19 1948

Immediate cause of death: Cardiac decompensation — Duration

Due to Arteriosclerotic heart disease

Due to Arteriosclerosis generalized

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Bobby L. Jones M. D.

Address Franklin Square Hosp. Date signed 10/19/48

667859

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1178

667859

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 W. Lanvale St.
(c) Hospital or institution: [redacted]
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days) ..

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Capt. Christian Olsen

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-14-5973

4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: W.
6 (b) Name of husband or wife: M. Elsie
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Aug 20, 1862
8. AGE: Years 86 | Months 2 | Days 0 | If less than one day: hr. ..... min. .....
9. Birthplace Arendal, Norway (Town, county, and state)
10. Usual Occupation Retired Sea Captain
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ,

MOTHER
14. Maiden Name Unknown
15. Birthplace ,

16 (a) Informant [redacted] Margaret Olsen
(b) Address 306 W. Lanvale St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3-23-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Jos. Ring Sons
(b) Address 5525 Park Heights Ave.

19 (a) 3 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 October 1948 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1 1948 to 20 Oct 1948 and that I last saw h (m) alive on 19 Oct 1948.

Immediate cause of death Intestinal hemorrhage Duration 6 months

Due to Duodenal ulcer Indefinite
Papilloma of bladder - retention

Due to

Other Conditions Arteriosclerosis, Cerebral

(Include pregnancy within 3 months of death)

Date of operation 21 Oct. 1948

Major findings of operation:

of autopsy As noted above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Hagenbuch Jr. M.D.
Address 120 E. Eutaw St. Date signed 20 Oct 48

VS 150

66780 ✓ 66780

66780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5227 St. Charles Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5227 St. Charles Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie F. Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife Samuel Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 6, 1861

8. AGE: Years	Months	Days	If less than one day
79	01	13	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Jacob Buck
13. Birthplace Germany

MOTHER
14. Maiden Name Heinricke Ortwein
15 Birthplace Germany

16 (a) Informant Mrs. Minnie Bigot
(b) Address 5227 St. Charles Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-48 (month) (day) (year)
(c) Cemetery or crematory Loraine Park
Location Baltimore Co. Md.

18 (a) Funeral director Irving Cypress
(b) Address 5005 Park Heights Ave

OCT 21 1948 (Date rec'd by registrar) Courtenay Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1948 at 12 15 P. M

21. I certify that death occurred on the date above stated that I attended deceased from May 1st 1947 to Oct 19 1948.
and that I last saw her alive on Oct 19 1948.

Immediate cause of death
1) Coronary Thrombosis — Duration 2 wks

Due to

Due to

Other Conditions Hypertension — ?
Heart Disease
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L Chambers M. D.
Address 4108 Liberty Hts Date signed 10/20/48

VS 150

X

66780-1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

66780-1
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa.
(e) Length of stay in Baltimore (yrs., mos., days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore,
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3040 Boston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK G. KLOCEK

3 (b) If veteran, name war ———

3 (c) Social Security Account No. ———

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ———

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1905

8. AGE: Years [illegible] Months - Days 19 If less than one day hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation: Crane Operator

11. Industry or business

FATHER
12. Name: George Klocek
13. Birthplace: Poland

MOTHER
14. Maiden Name: Agnes Feret
15. Birthplace: Poland

16 (a) Informant: Mr. Barowski
(b) Address: 622 S. Curley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22, 1948 (month) (day) (yr.)
(c) Cemetery or crematory: St. Stanislaus
Location: Baltimore, Maryland

18 (a) Funeral director: Fred W. Ozazewski
(b) Address: 1930 Eastern Ave.

[illegible] (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20, 1948, at 8:25 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute Congestive Cardiac Failure

Due to: Congestion of Both Lungs

Other Conditions: Fatty Liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ——— at ——— M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Howard J. Madden M.D.
Medical Examiner.
Date signed 10-20-48

VS 151

925

6778 52

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

927

Registered No. 6778 52

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution:
Home for The Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Mary Drapczynska

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 15, 1859

8. AGE: Years	Months	Days	If less than one day
88	11	2	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thos Shymanski
13. Birthplace

MOTHER
14. Maiden Name Mary Jawanski
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23 1948 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Rita Windefeld
(b) Address 900 East Biddle St Baltimore, Md

19 (a) OCT 21 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 1948, at 10:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to Oct 20 1948, and that I last saw h alive on Oct-18 19 48.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	10 yr
Due to	
Other Conditions Arteriosclerosis	10 yr

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall
Address 1631 E North Ave Date signed 10/21/48 M. D.

VS 150

16678-3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

Registered No. 16678-3

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city limits, give township or district and name of incorporated town)
(d) Street No. Room 301 Knights of Columbus Cathedral & Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME C. HOWARD (H.) LENTZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Esso Standard Oil Co.

FATHER
12. Name George H. Lentz
13. Birthplace Balto. , Md.

MOTHER
14. Maiden Name Mary A. Cullen
15. Birthplace Balto., Md.

16 (a) Informant Frank Lentz
(b) Address 1906 Chelsea Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Catherdral
Location Balto., Md.

18 (a) Funeral director Thos. E. Thomas
(b) Address 1426 Light St.

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20, 1948 at 12:56 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushed Chest.
Multiple fractures
Hemorrhage due to multiple incised wounds of wrists

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 20/48 Approx. 12:30 P.M.
(b) Where did injury occur? Knights of Columbus Cathedral & Madison Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Sharp instrument - jumped from Building

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 10/20/48

VS 151

6678 1/2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6678 1/2

Registered No. 928

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 E. 23rd St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Bellona Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis T Balcke (LOUIS THEODORE BALCKE)

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1887

8. AGE: Years	Months	Days	If less than one day
60	10	2	hr. min.

9. Birthplace Mt. Pleasant, Iowa (Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business Bureau Internal Revenue

FATHER
12. Name William F. Balcke
13. Birthplace Vlotho, Germany

MOTHER
14. Maiden Name Louise Hoffman
15. Birthplace Iowa

16 (a) Informant Mrs. Winslow
(b) Address Goucher College Campus, Towson Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/21/48 (month) (day) (year)
(c) Cemetery or crematory
Location Pekin, Ill.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 21 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1948, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948 to Oct 21 1948.
and that I last saw him alive on Oct 20 1948.

Immediate cause of death Heart failure
Pulmonary edema
Duration 10 day

Due to Rheumatic cardio vascular disease
Duration 40 yrs +

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Specific findings of autopsy ~~Autopsy refused, Parents request~~

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 100 E 23rd St Date signed 10/21/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

16785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 16785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1329 Mt. Royal Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 1329 Mt. Royal Ave.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES F. LUSTNAUER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	no	male	white	married

6 (b) Name of husband or wife L. Kathryn Lustnauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1884

8. AGE: Years	Months	Days	If less than one day
63	11	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Supervisor of Education
11. Industry or business State Bd. of Correction

FATHER
12. Name Frederick W. Lustnauer
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Emma G. Schreiner
15. Birthplace Balto., Md.

16 (a) Informant Mrs. L. Kathryn Lustnauer
(b) Address 1329 Mt. Royal Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 23 1948 (Date received by registrar) (b) Huntington Woodyard M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20, 1948 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1942 to Oct 20 1948, and that I last saw him alive on Oct 20 1948.

Immediate cause of death	Duration
Cardiac Dilatation & Pulmonary edema	Sudden attack
Due to Myocardial Insufficiency	Prior to 1942
Due to Hypertension	Prior to 1942
Other Conditions Healed pulmonary tuberculosis; Obesity	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. J. Tickner & Sons
Address 12 E Lafayette St Balto 21 Date signed 10/21/48 M D

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3878-6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 3878-6

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be typewritten or plainly supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St.
(c) Hospital or institution:
Sinai Hospital 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1746 Lemont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Doering

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widower

6 (b) Name of husband or wife Louisa E. Doering
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21st, 1872

8. ACE: Years	Months	Days	If less than one day
76	1	29	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business B. & O. R.R.

FATHER
12. Name Louis Doering
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Paul W. Doering
(b) Address 32 Fuller Ave.

17 (a) burial (b) Date thereof 10/23/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Pauls Lutheran
Location Violetsville

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7101 Belair Rd.

19 Oct 21 1948 (Huntington Williams, M.D.)
(Registered by) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20 1948, at 4:13 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1948, to 10-20 1948, and that I last saw him alive on 10-20 1948.

Immediate cause of death	Duration
Acute Myocardial Infarction	
Due to Coronary Occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome Gahen M. D.
Address Sinai Hosp. Date signed 10/20/48

VS 150

Oc 667857

A MEDICAL EXAMINER'S CASE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667857 Registered No. 15c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1372 N. Caney St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Taylor

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1948

8. AGE: Years	Months	Days	If less than one day: hr.	min.
42	5	1	1906	

9. Birthplace Ashburn Logan Ky. (Town, county and state)
10. Usual Occupation Shipfitter
11. Industry or business Sparrows Point

FATHER
12. Name Matthew Taylor
13. Birthplace Dennis, Ky.

MOTHER
14. Maiden Name Lucille Norton
15. Birthplace Dennis Ky.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory
Location Detroit, Michigan

18 (a) Funeral director Wilbur Reese II
(b) Address 108 Washington St. Annapolis Md

19 (a) (Date rec'd by) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1948, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1948, to 10-19 1948, and that I last saw him alive on 10-19 1948.

Immediate cause of death Respiratory Obstruction — Duration

Due to Peritonsillar abscess and acute mediastinitis

Due to

Other Conditions

CERTIFICATION APPROVED BY

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William D. Dieterich, M. D.
Address Johns Hopkins Hospital Date signed 10-20-48

Through the Medical Examiner's Case. Released to Hospital

G67818

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G67818 Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 N. Duncan
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 N. Duncan (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine K. Hejl

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph Hejl | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1870

8. AGE: Years 78 | Months 5 | Days 24/25 | If less than one day hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John Mipes
13. Birthplace Czecho-Slovakia

MOTHER
14. Maiden Name Catherine Roman
15. Birthplace Czecho Slovakia

16 (a) Informant Josephine Peroutka
(b) Address 806 N. Glover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Evachson
(b) Address 900 N. Chester St

19 (a) 1948 (Date filed by registrar) (b) Washington, Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1948, at 5:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24-48 19 to 10-19- 1948, and that I last saw h alive on 10-19- 1948

	Duration
Immediate cause of death: Cerebral hemorrhage	5 days
Due to Hypertension	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eleanor B. Jones, M.D. M. D.
Address 648 N. Linwood Ave Date signed 10-19-48

VS 150

67878 BALTIMORE CITY HEALTH DEPARTMENT ✓ X Registered No. 16678

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State WVa (b) County Dodd
(c) City or town Central Sta
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Black

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 1909

8. AGE: Years	Months	Days	If less than one day
39	4	6	hr. min.

9. Birthplace Central Sta WVa (Town, county, and state)
10. Usual Occupation Office
11. Industry or business

FATHER
12. Name John Willis
13. Birthplace WVa

MOTHER
14. Maiden Name Celia Jane Dodson
15. Birthplace WVa

16 (a) Informant Mary Brown
(b) Address Ellenboro

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10 22 48 (month) (day) (year)
(c) Cemetery or crematory IOOF
Location Westmoreland WVa

18 (a) Funeral director Geo. M. Junkerton
(b) Address 811 N. Wolfe St.

19 OCT 22 1948 (Date rec'd by registrar) Huntington Williamson, Mgr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1948, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 1948, to 10-21 1948, and that I last saw h C B alive on 10-21 1948.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertensive Cardiovascular Renal disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome Gaber M. D.
Address Sinai Hosp Date signed 10-21-48

VS 150

X

G67870

LCH 123863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G678.0

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1828 Mosher Street (If rural give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Bertha Doran

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day hr.	min.
68				

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Hugh Hancock

13. Birthplace Texas

MOTHER 14. Maiden Name Susie James

15. Birthplace Texas

16 (a) Informant Balto. City Hosp. records

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24-48 (month) (day) (year)

(c) Cemetery or crematory Cemetery

Location Danville Ky.

18 (a) Funeral director Sears A. Henry.

(b) Address Centreville Md.

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20/48 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19/48 to 10/20/48 and that I last saw her alive on 10/20/48

Immediate cause of death: Arteriosclerotic heart disease & cardiac failure — Duration: 4 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John E. Bechtold

Address Balto City Hosp. Date signed 10-21-48 M. D.

X Bechtold

VS 150

G67871

JL - 45125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 D ✓

Registered No. G67871

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife Daisy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 2, 1878

8. AGE: Years	Months	Days	If less than one day
70	7	14	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Carl Johnson
13. Birthplace ?

MOTHER
14. Maiden Name Anna Wilson
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 6 - 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 OCT 22 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1948 at 6.25 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1939 to Sept. 16 1948, and that I last saw him alive on Sept. 16 1948

Immediate cause of death Carcinoma of Penis

Due to

Due to

Other Conditions Left hemiplegia Arteriosclerotic heart disease
(Include pregnancy within 3 months of death)

Date of operation Sept 9 1948

Major findings of operation: Carcinoma of Penis

of autopsy:

Duration: 10 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman Ford MD
Address 4140 Eastern Ave Date signed 10/19/48

VS 150

G67872

AB-102814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G67872

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 32yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Dillard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife Charlotte (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 4-1896

8. AGE: Years	Months	Days	If less than one day
52	7	14	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name John Dillard (D
13. Birthplace Va.?

MOTHER
14. Maiden Name Mary Desmond (D
15. Birthplace Va.?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 6 - 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 22 1948 (b) (Name of cemetery) Interment Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept- 18- 1948, at 12.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-11- 1946 to 9-18- 1948 and that I last saw him alive on 9-18- 1948

Immediate cause of death
Cardiac failure.
Due to Arteriosclerotic Heart Disease.
Due to
Other Conditions Anemia, unexplained
(Include pregnancy within 3 months of death)

Duration
2 days
2 yrs
1 yr.

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H Vinkers J.
Address Balto City Hosp Date signed 10 Oct 48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G67873

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Redwood & Greene Sts.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. 5 (If outside city or town limits, write RURAL and give town)

(d) Street No. 1627 Abbey St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lacy Chambers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, (married), widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
40				

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Orderly

11. Industry or business: University Hosp.

FATHER 12. Name: Wm.

13. Birthplace: N. Carolina

MOTHER 14. Maiden Name: Roundy

15. Birthplace: S. Carolina

16 (a) Informant:

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School OCT 15 1948

18 (a) Funeral director: Commissioner of Health

(b) Address

19 OCT 22 1948 (Date rec'd by registrar) (b) Entington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1948 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 1948 to Oct. 12 1948 and that I last saw h[illegible] alive on Oct. 12 1948.

Immediate cause of death	Duration
cardiac failure	
Due to possible acute myocardial infarction	
Due to arteriosclerotic brain disease	
Other Conditions possible pulmonary infarction	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify)

(e) Means of injury

23. Signature John White M D

Address University Hosp Date signed 10-12-48

VS 150

G67874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G67874

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 George Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES CLOCK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation "

11. Industry or business "

FATHER
12. Name "
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant ———
(b) Address ———

17 (a) (Burial, cremation, or removal) (b) Date thereof

(c) Cemetery or crematory
Location University Medical School OCT 1 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 22 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1948, at 12.25 PM

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner
Date signed SEPT. 20, 1948

G67875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G67875
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Briscoe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SHELLIE GRIFFEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Unknown
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 13 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29, 1948 at 6.15 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/29/48

VS 151

G67876

JL- 123472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G67876 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. No Home Address (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Albert Wilspn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. ? ? ?

8. AGE: Years 45 ? | Months | Days | If less than one day: hr min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name William Henry Wilson

13. Birthplace Md.

MOTHER

14. Maiden Name Mary ?

15. Birthplace Va.

16 (a) Informant B.C.H. Records

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School OCT 19 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 OCT 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1948, at 5 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1948 to Oct. 8 1948, and that I last saw him alive on Oct. 8 1948

	Duration
Immediate cause of death Pulmonary edema and cerebral embolism	1 day
Due to Paroxysmal tachycardia	1 day
Due to Hypertensive Cardiovascular disease	2-3 years
Other Conditions Bronchopneumonia	1 day.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature L. Stutzman M.D.

Address Balto. City Hosp. Date signed 10-8-48

VS 150

G67877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 B

Registered No. G67877

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 66 days

(e) Length of stay in Baltimore (yrs., mos., or days): 66 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Texas (b) County: Galveston

(c) City or town: (If outside city or town limits, write RURAL and give town)

(d) Street No.: 205- 20th St. (If rural give location)

(e) Citizen of foreign country? ? (Yes or No)

If yes, name country:

3 (a) FULL NAME: FRED ALBERT ANDERSEN

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: 550-26-1897

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1880

8. AGE: Years	Months	Days	If less than one day
67	11	7	hr. min.

9. Birthplace: Norway (Town, county, and state)

10. Usual Occupation: Engineer

11. Industry or business: Seafarer

FATHER
12. Name: Anders Albertson
13. Birthplace: Norway

MOTHER
14. Maiden Name: Mathilda Albertson
15. Birthplace: Norway

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-22-48 (month) (day) (year)

(c) Cemetery or crematory: St Peters
Location: Lorman Cem.

18 (a) Funeral director: Ray B Wolverton Inc
(b) Address: 403- E-25th St.

19 OCT 22 1948 (Date rec'd by registrar) (By) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1948, at 5:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1948 to Oct. 18 1948, and that I last saw him alive on Oct. 18 1948.

Immediate cause of death	Duration
1- Carcinoma of tongue with regional metastasis	18 mos.
2- Bronchopneumonia	3-4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: John L. Wilson

John L. Wilson, Sr. Surgeon M. D.

Address: Clinical Director Date signed 10/21/48

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

662878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G62878

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ft. of William Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State U (b) County
(c) City or town N (If outside city or town limits, write RURAL, and give town)
(d) Street No. K No. Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country W N

3 (a) FULL NAME DANIEL KELLY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace U (Town, county, and state)
10. Usual Occupation N
11. Industry or business K

FATHER
12. Name N
13. Birthplace O W

MOTHER
14. Maiden Name U N
15. Birthplace N

16 (a) Informant K
(b) Address N O

17 (a) (Burial, cremation, or removal) (b) Date thereof N (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 13 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 19 48 at 7:05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning
Acute alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found: 10-2-48 at 6:30 A. M.
(b) Where did injury occur? Found: Ft. of William St
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work?
(d) Means of injury Found drowned

23. Signature [signature] M.D.
Medical Examiner.
Date signed 10-2-48

VS 181

correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

G67879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83

Registered No. G67879

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Found: Jones Falls
(c) Hospital or institution:
East & Baltimore St
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State X D.C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 12th St. N.E.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY DANFORTH

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month, day, year)
(c) Cemetery or crematory
Location University Medical School OCT 1 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 22 1948 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948, at 9:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Aug. 29, '48 at Approx. 9:30 A.M.
(b) Where did injury occur? Found in Harbor off Pier #6
(c) Did injury occur at home, on farm, industrial place, in public place? Public place While (at work) No
(d) Means of injury Drowning

23. Signature Emil Reyna M.D.
Medical Examiner
Date signed 8-30-48

G67880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G67880 Registered No.

1. PLACE OF DEATH: 5440
(a) Baltimore City, Maryland
(b) Street address 4045 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4dys.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville (If outside city or town limits, write RURAL and give town)
(d) Street No. York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMMA ALICE CONKLING

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William N. Conkling
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1879

8. AGE: Years 68 | Months 10 | Days 26 | If less than one day — hr. — min.

9. Birthplace Baldwin, Balto. Co., Md. (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name George W. Francies
13. Birthplace Baldwin, Md.

MOTHER
14. Maiden Name Fannie Porter
15. Birthplace Baldwin, Md.

16 (a) Informant John Conkling
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22, 1948 (month) (day) (year)
(c) Cemetery or crematory Chestnut Grove Cem.
Location Jacksonville, Balto. Co., Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Transcribed for Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1948 to Oct 19 1948, and that I last saw her alive on Oct 18 1948.

Immediate cause of death	Duration
Hypertension & Arteriosclerosis	15 yrs.
Due to Chronic myocarditis	
Due to	
Other Conditions Uremia, Urinary retention (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. V. Harbold M. D.
Address 4706 Harford Road Date signed 10/21/48

VS 150

G67881

ES-121736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G67881

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 EASTERN AVE

(c) Hospital or institution: BALTO. CITY HOSPITALS.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days.

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 641 Houser St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sarah Cook

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 15, 1880

8. AGE: Years	Months	Days	If less than one day
68	2	5	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Jim Locke

13. Birthplace Md.

MOTHER — 14. Maiden Name Betty Chew

15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS

(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director James A Davis

(b) Address 142 W. 7th St

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Burlington Williams Mort

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20- 19 48 at 5:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 19 48 to 10-20 19 48 and that I last saw her alive on 10-20 19 48

Immediate cause of death	Duration
Myocardial Failure	Hours
Due to Arteriosclerosis	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be changed statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature M. D.

Address Date signed

VS 150

667882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 100 a

Registered No. 667882

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Lanow Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town, write RURAL and give town)
(d) Street No. 5312 Ethelbert Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Ruth Saltstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Murray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 25 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Louis Miller

13. Birthplace Russia

MOTHER 14. Maiden Name Fannie

15. Birthplace Russia

16 (a) Informant Murray Saltstein

(b) Address 5312 Ethelbert Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-48 (month) (day) (year)

(c) Cemetery or crematory United Hebrew

Location Washington Boulevard

18 (a) Funeral director Jack Rawsome

(b) Address 2400 Eutaw Place

19 (a) Date received by registrar OCT 22 1948 (b) Interment in Williamsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Oct. 1948, at 4:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Anaphylactic Shock

Due to Intravenous Injection of Sodium Morphate

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Oct. 21, 1948 Aprox. 2:30 P.M.

(b) Where did injury occur? 2519 Eutaw Place

(c) Did injury occur at home, on farm, industrial place, in public place? Dr's office While at work?

(d) Means of injury Intravenous injection of sodium morphate

23. Signature Wm. H. Kammer M.D. Medical Examiner.

Date signed 21 Oct. 48

VS 151

G67883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G67883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Edgevale Road
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) ~~County~~ Baltimore City
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Edgevale Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN ROBEY LENGNICK

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry A. Lengnick
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr): June-16-1874

8. AGE: Years 74 | Months 4 | Days 4 | If less than one day: ____ hr. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: None

FATHER
12. Name: Joseph Henry Marston
13. Birthplace: ? ? U. S. A.

MOTHER
14. Maiden Name: Elizabeth Helen Snyder
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Bessie M. Walker (sister)
(b) Address: 608 Edgevale Road, City #10.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof: Oct-23-1948 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Baltimore, Maryland

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 W. North Avenue, City #1.

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1948, at 12 N.

21. I certify that death occurred on the date above stated; that I attended deceased from — 1936, to Oct 20 1948 and that I last saw h e alive on Oct 19 1948.

Cause	Duration
Immediate cause of death: Congestive heart failure	July 1948
Due to: Arteriosclerotic heart disease	
Due to: Arteriosclerosis Symptoms	since 1936
Other Conditions: Hypertension	since 1926

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Pl. Date signed 10/21/48

VS 150

G67884 LCH-123603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G67884 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 E. Franklin Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Dorsey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?, ? ?

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Balto. City Hosp. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. Frances A. Hensley
(b) Address 578 W. Biddle St.

19 (a) 10-22-1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19/48 19 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8/48 19 to 10/19/48 19, and that I last saw her alive on 10/19/48 19.

Immediate cause of death ? Poss. coronary occlusion? Poss. pul. embolus? — Duration Instant

Due to

Due to

Other Conditions Cachexia, malnutrition
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No significant

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. T. Nelson M. D.
Address Balto City H. Date signed 10-21-48

VS 150

067885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 174A

Registered No. 067885

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: HOWARD
(a) State Md. (b) County Baltimore
(c) City or town ~~Baltimore~~ Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Edmondson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Edward Pruitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	(Married)

6 (b) Name of husband or wife Sally Pruitt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28 1897

8. AGE: Years	Months	Days	If less than one day
51	8	19	hr. min.

9. Birthplace Salem North Carolina
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Jake Pruitt
13. Birthplace Va

MOTHER
14. Maiden Name Patrecia Childers
15. Birthplace Va

16 (a) Informant Pauline F Warner
(b) Address Harmons Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-48 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md

18 (a) Funeral director D C Higinbotham
(b) Address Ellicott City Md

19 (a) OCT 22 (Date rec'd by registrar) (b) Torrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21-48 19 . at 5-00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 19 to 10-21 19 .
and that I last saw him alive on 10-21-4819

Immediate cause of death	Duration
Resp failure	
Portal Cerrhosis	
due to	
Due to Chronic alcoholism	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Halpern M. D.
Address University Hosp Date signed 10-21

VS 150

X

G67886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2748 Lively Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Parsons

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 218-10-0899

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs Evelyn Parsons
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 22, 1913

8. AGE: Years: 35 | Months: 7 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business

FATHER
12. Name: John Parsons
13. Birthplace: England

MOTHER
14. Maiden Name: May Kirby
15. Birthplace: Maryland

16 (a) Informant: John Parsons
(b) Address: 2748 Lively Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1948 (month) (day) (year)

(c) Cemetery or crematory: Parkwood
Location:

18 (a) Funeral director: Chas. E. Sisson-Ent. Sons
(b) Address: 118 W. Mt. Royal Ave Baltimore, Md.

19 OCT 22 1948 (b) (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1948, at 2:00 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-9 1948, to 10-21 1948, and that I last saw h[illegible] alive on 10-21 1948

Immediate cause of death: Acute, ulcerative Colitis — Duration: 4 weeks
Due to: Pneumonia — 4 days
Due to: due to perforation of ulcer
Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature: Vernon H Norwood M. D.
Address: Church Home Hospital Date signed 10-21-48

VS 153

67887 BC-48-23051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 67887

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave & John St
(c) Hospital or institution: Woman's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 4/7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 N. Linwood Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Brannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 21, 1948

8. AGE: Years 0 | Months 0 | Days 1day | If less than one day hr. min.

9. Birthplace Baltimore City, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Hugh Edward Brannon

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Dorothy Katherine Smith

15. Birthplace Phila., Pa.

16 (a) Informant Dorothy Brannon

(b) Address 800 N Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore Md

18 (a) Funeral director J. G. IMUNEK, FUNERAL HOME

(b) Address 1916 Madison St

OCT 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21, 1948 at 4:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from morning 10-21-1948, to afternoon 10-21-1948, and that I last saw her alive on October 21, 1948

Immediate cause of death: Premature infant & Respiratory & Cardiac death — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Bean, M.D.

Address Woman's Hospital Date signed 10-21-48

VS 190

G67888

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

Registered No. G67888

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 5924 Greenhill Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN A. WEILBRENNER

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-8155

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Minnie Weilbrenner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1883

8. AGE: Years	Months	Days	If less than one day
65	9	7	hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Adam Weilbrenner
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Ostertag
15. Birthplace Balto., Md.

16 (a) Informant Mrs. John A. Weilbrenner
(b) Address 5924 Greenhill Ave. Balto. 6, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director LASSAHN FUNERAL HOME
(b) Address 7401 Belair Rd.

19 OCT 22 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1948, at 2 A. M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage
traumatic
TRAUMATIC

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-18-48 at 3.0[illegible] P. M.
(b) Where did injury occur? Home of John Lattie Westwood Ave.
(c) Did injury occur at home, on farm, industrial place or public place? home While at work? no
(d) Means of injury fell down steps inside

23. Signature Earl M. Page, M.D. Medical Examiner
Date signed 10-22-48

VS 151

067889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 A

Registered No. 67889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 Tuxedo St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Webster Green

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-22-1318

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2-9-29

8. AGE: Years	Months	Days	If less than one day
19	8	12	hr. — min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Balto City Maintenance

FATHER
12. Name Clinton W Green
13. Birthplace Balto Md

MOTHER
14. Maiden Name Catherine C Rosedge
15. Birthplace Balto Md

16 (a) Informant Father
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25-1948 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Baltimore Co. Maryland

18 (a) Funeral director Durage Funeral Home
(b) Address 3031 Falls Road

19 OCT. 22 1948 Washington Williams (Registrar)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 21 - 1948, at 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1948 to 10-21-1948, and that I last saw him alive on 10-21-1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Intracranial Hemorrhage	20 hrs
Due to Thrombocytopenic purpura	8 mos
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature Allyn F Judd M. D.
Address Mercy Hospital Date signed 10-21

VS 150

667890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 667890

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 N Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Forbes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give [illegible] years

7. Birth date of deceased (mo., day, yr.) [illegible] 1908

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Md. ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Forbes
13. Birthplace ?

MOTHER 14. Maiden Name Liza Adams
15. Birthplace ?

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof [illegible]/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. D. Kelly
(b) Address 1303 Pressman St

19 (a) Oct 22 1948 (Date rec'd by registrar) (b) Lexington & Williams Sts (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1948 to Oct 20 1948 and that I last saw her alive on Oct 20 1948

Immediate cause of death Uremia — Duration

Due to Malignant nephrosclerosis

Due to Hypertensive cardiovascular renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Hypertrophied heart, small kidneys

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature John Colley Harvey
Address Johns Hopkins Hospital Date signed Oct 22 48

VS 150

G67891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G67891 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623-N Bethel
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 N. Bethel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Alese Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
52	?	?	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Unemployed Unknown
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs Herman B. Ross
(b) Address 902-N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 22 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A.A. County

18 (a) Funeral director Mrs Cath. A. Elliott Dept.
(b) Address 1129 N. Carlton St.

19 (a) (Date received by Registrar) (b) Registrar
OCT 22 1948 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1948 at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1948 to 10/18 1948 and that I last saw her alive on 10/18 1948

Immediate cause of death Sub acute glomerulo-Nephritis

Due to Renal Insufficiency

Due to

Other Conditions Cardio-Vascular disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. E. Brady
Address 1514 Division St Date signed 10/20/48 (M. D.)

VS 150

X

G67892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

484

G67892 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1875 E. Biddle St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto:

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1875 E. Biddle St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Jessie Marie Jones Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C.	Married

6 (b) Name of husband or wife Bailey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/15/07

8. AGE: Years	Months	Days	If less than one day
41	9	4	hr. min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER

12. Name Jessie Jones

13. Birthplace Va.

MOTHER

14. Maiden Name Adie Smith

15. Birthplace Va.

16 (a) Informant Elnora Collins

(b) Address 1875 E. Biddle St.

17 (a) Burial (b) Date thereof 10/22/48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.

Location

18 (a) Funeral director Joseph D. Lock

(b) Address 1304 N. Central Ave

OCT 22 1948

(a) Local registrar (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19 1948 at 6.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30 1947 to 10/19 1948.

and that I last saw h[illegible] alive on 10/19 1948.

Immediate cause of death

Cancer Peritonei

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

10 Months

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Edward A. Lefrak, M.D.

Address 522 N. Bond St. Date signed 10/21/48

X

HH 4 67893

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1572

G67893 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs. mos. or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Charleston (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 542a Route #2 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas O Hill
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-14-48

8. AGE: Years	Months	Days	If less than one day
	2	8	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Ralph Hill
13. Birthplace W. Va

MOTHER 14. Maiden Name Elizabeth Childs
15. Birthplace W. Va

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Charleston
Location West Virginia

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson ave

OCT 22 1948 (Date rec'd by registrar)
(b) Huntington Williamson, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22 1948, at 4:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12 1948 to 10-22 1948, and that I last saw him alive on 10-22 1948

Immediate cause of death Respiratory failure — Duration
Due to Possible cerebral maldevelopment
Due to
Other Conditions Marasmus malaria
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Hyperemia & Large Bowel

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Markowitz MD
Address Johns Hopkins Hospital Date signed 10/22/48

VS 130

X

G67894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G67894
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12a 4 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2723 W. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dewitz, William Sr

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-16-8219A

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife Widowed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 22, 1865

8. AGE: Years 83 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business

FATHER
12. Name CHARLES DEWITZ
13. Birthplace GERMANY

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant William Dewitz Jr
(b) Address 2723 W. FAIRMOUNT AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location

18 (a) Funeral director Thomas J. Kenny Inc
(b) Address 1600 Hollins St

19 (a) 10/22/1948 (Registered by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21 1948, at 2:01 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1948 to 10/21 1948 and that I last saw him alive on 10/21 1948.

Immediate cause of death Peritonitis — Duration

Due to Gangrene of Bowel (entire Bowel)

Due to Thrombosis of the Superior Mesenteric Vessel Vein

Other Conditions Perforation of Ileum
(Include pregnancy within 3 months of death)

Date of operation 10/20

Major findings of operation: L.T.S. Above. Peritonitis: Perforation of

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert K. Kennedy M. D.
Address 1600 Hollins St Date signed 10/21

X

G67895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 001

Registered No. G67895

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town RURAL Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marley Park (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Howard Ochs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1941

8. AGE: Years	Months	Days	If less than one day
7	7	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Student
11. Industry or business Richard Henry Lee Elem. School

FATHER
12. Name Howard Lawrence Ochs
13. Birthplace Baltimore

MOTHER
14. Maiden Name Doris Marie Schline
15. Birthplace Brooklyn, Md.

16 (a) Informant: Mrs. Doris Ochs
(b) Address: Marley Park, Glen Burnie P.O. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cemetery
Location Glen Burnie

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) OCT 26 1948 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1948 5:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6/ 1948 to 10/22/ 1948 and that I last saw him alive on 10/22/ 1948

Immediate cause of death	Duration
Lueral Toxemia	
Due to Typhoid Fever	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Ulcerations of intestines

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ray E. Persons, Jr. M.D.
Address Johns Hopkins Hosp. Date signed 10/22/48

VS 150

G67896

AB-123580

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 130

G67896 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2838 Denham Circle, Cherry Hill
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2838 Denham Circle, Cherry Hill (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalee Stevenson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 7- 1932

8. AGE: Years	Months	Days	If less than one day
16	6	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Stevenson
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Fennels
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn, Maryland

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Avenue

19 (a) (Date rec'd by registrar) (b) Entering for Williams M.D.

OCT 22 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19- 1948, at 7 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7- 1948, to 10-17- 1948, and that I last saw her alive on 10-17- 1948.

Immediate cause of death Uremia — Duration

Due to sub-acute glomerulonephritis

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D. Nelson M.D.
Address BCH Date signed 10-21

G67897 ✓ G67897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 N. Carey St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mrs Lee Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Femal

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) Oct. 26 1883

8. 65 Years | Months 11 | Days 24 | If less than one day ..... hr ..... min.

9. Birthplace Blackstone Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Archer Williams
13. Birthplace Blackstone Va

MOTHER 14. Maiden Name Elvira Neal
15. Birthplace Blackstone Va

16 (a) Informant Mr. Clara Hardesty
(b) Address 612 N. Carey St.

17 (a) Burial (b) Date thereof Oct. 24. 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park
Location Arbutus Maryland

18 (a) Funeral director Elroy O. Wilson
(b) Address Iooo Brantly Ave.

19 (a) OCT 22 1948 (b) .....
(Date rec'd by registrar)

Huntington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 1948 at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sep. 10 1948 to Oct. 20 1948. and that I last saw her alive on Oct. 20 1948.

Immediate cause of death: Congestive Heart Failure — Duration: 3 month

Due to .....

Due to H.C.V.

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury .....

23. Signature Geo. J. McDonald M. D
Address 344 N. Carey St Date signed 10/22/48

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67898

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 180

G67898 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Madison Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: RUTH NEWTON

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Albert Newton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-13-1918

8. AGE: Years 30 | Months 8 | Days 5 | If less than one day: hr. min.

9. Birthplace: Petersburg, Va. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Mathew Garrett
13. Birthplace: South Carolina

MOTHER
14. Maiden Name: Emma Jones
15. Birthplace: Virginia

16 (a) Informant: Albert Newton (H)
(b) Address: 1409 Madison Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 22-48 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Mem'l Pk.
Location: Baltimore County, Md.

18 (a) Funeral director: Charles G. Cooper
(b) Address: 512 Carrollton Avenue

19 (a) (b) Registrar

Oct 22 1948 Registered by registrar Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1948, at 2:20 PM

21. I certify that I took charge of the remains described above, held an Insp & Inquiry (Autopsy, Inspection or Inquiry) thereof and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: 1st and 2nd degree burns 60% body

Due to

Other Conditions

(Include pregnancy within 3 months of death.)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-16-48 at 11:50 P M.
(b) Where did injury occur? 1409 Madison Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury: 2nd flr of home afire--trapped in room

23. Signature: [illegible] M.D. Medical Examiner.
Date signed 10-19-48

X

667899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No. 667899

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2020 Cliftwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2020 Cliftwood Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Pickel

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17-1867

8. AGE: Years	Months	Days	If less than one day: hr.	min.
80	10	3+		

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired - Packer
11. Industry or business Retail Furniture

FATHER
12. Name George H. Pickel
13. Birthplace Germany

MOTHER
14. Maiden Name Kunigunda Meier
15. Birthplace Germany

16 (a) Informant J. Earl Pickel
(b) Address 4233 Sheldon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23-1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto. Co.

18 (a) Funeral director Mrs. Mrs. John W. Pickel's Son
(b) Address 5311 Edmondson Ave

19 OCT 22 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1948, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17 1947 to 10/20 1948
and that I last saw her alive on 10/20 1948

Immediate cause of death	Duration
Bronchopneumonia	2 days
Coronary Sclerosis	
Due to Arteriosclerosis	
Hypertension Cerebrovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Mesa M. D.
Address 1427 E North Ave Date signed 10/21/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

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67900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 67900

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edgewood Nursing Home
(c) Hospital or institution: Bellona and Belvidere ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4502 Bawleys Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Katawski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Stella Katawski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep 15 1887

8. AGE: Years	Months	Days	If less than one day
61	1	6	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Carpenter B. O. R. R. Co.
11. Industry or business

FATHER
12. Name Baltazar Katawski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Makowski
15. Birthplace Poland

16 (a) Informant Mrs Stella Katawski
(b) Address 4502 Bawleys Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary (Rc)
Location Baltimore County

18 (a) Funeral director John M. Welsh
(b) Address 407 S. Chester Street

19 OCT 22 1948 (Date rec'd by registrar) Registrar Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1948 at 12 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from July 16 1948 to Oct 21 1948. and that I last saw h alive on Oct 20. 1948

Immediate cause of death	Duration
Bronchial pneumonia	2 days
Due to Acute Bronchitis	2 wks.
Due to Hypertrophy & arteriosclerosis	4 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature N. F. McDarrah M. D.
Address 1136 Patapsco Ave Date signed 10/24/48

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 dr Registered No. 667901

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2228 Ruggles Ave
(c) Hospital or institution:
Md University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) Country
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2228 Ruggles Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Ehrlich

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Walter Ehrlich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 - 1874?

8. AGE: Years	Months	Days	If less than one day: hr.	min.
74	2	7		

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Gustav Doggel
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Walter E
(b) Address Lansdowne Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25-46 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director Edw Faulmann
(b) Address 2228 Ruggles Ave Balto Md.

19 (a) OCT 22 1946 Huntington Williams MD
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1946, at 1 32 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1946 to Oct 21 1946, and that I last saw h alive on Oct 21 1946

Immediate cause of death	Duration
Respiratory failure	
Due to Lobar pneumonia	
Due to	
Other Conditions Carcinoma of Rectum	

(Include pregnancy within three months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank E Bloomquist
Address University Hospital Date signed 10/21/46 M D

VS 150

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G67902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 1/2 -

Registered No. G67902

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 625 Cokesbury Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Dolores Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1929

8. AGE: Years	Months	Days	If less than one day: hr.	min.
18	10	29		

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Tailoress

11. Industry or business

FATHER

12. Name William Joseph Cook

13. Birthplace Maryland

MOTHER

14. Maiden Name Josephine Cook

15. Birthplace Maryland

16 (a) Informant HOSPITAL RECORDS

(b) Address Union Memorial Hospt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer City

Location

18 (a) Funeral director WIEDEFELD & SON

(b) Address GREENMOUNT AVE & 22ND

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 1948, at 10:32 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1948 to Oct. 20 1948, and that I last saw h alive on Oct. 20 1948

Immediate cause of death	Duration
Congestive heart failure	6 mo.
Due to Rheumatic fever	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John R. Smith, Jr. M.D.

Address Union Mem. Hosp. Date signed 10/20/48

VS 189

667903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 667903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 Ensor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 Ensor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country.

3 (a) FULL NAME Mildred A. Chandler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 8- 1924

8. AGE: Years	Months	Days	If less than one day
24	7	11	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Robert L. Chandler
13. Birthplace Va

MOTHER
14. Maiden Name Blanche Morrow
15. Birthplace Va

16 (a) Informant Blanche Chandler
(b) Address 712 Ensor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23-48 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial Park
Location Baltimore

18 (a) Funeral director Payne Sanders
(b) Address 1412 E. Preston St

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Huntington Nekimeyer, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19-1948 at 6 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1-48 to 10-19-1948 and that I last saw her alive on 10-19-1948.

Immediate cause of death Bronchio Pneumonia — Duration 2 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jas. R. Blake M.D.
Address 1603 N. Caroline St 10-21-48

V S 150

This certificate should be typewritten. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

0134 Registered No. G67904

Typewrite or print in PERMANENT BLACK INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 W. Mosher st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 W. Mosher st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellenie Victoria Jones Hall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Charles Hall
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Florence S. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Lucious Jones
13. Birthplace S.C

MOTHER 14. Maiden Name Viner Singletary
15. Birthplace S.C

16 (a) Informant Otis C. Jones
(b) Address Louisa Louisa Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Balto. County

18 (a) Funeral director Carpenter & Sanders
(b) Address Preston & Eutaw

19 (a) OCT 22 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19 1948 at 7 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1948 to 10/19 1948.
and that I last saw her alive on 10/18 1948.

Immediate cause of death Pulmonary Tuberculosis — Duration 4 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1111 Lee Date signed 10/19/48 (M. D.)

VS 150

G67905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G67905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 N. Eulaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 N. Eulaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. A. Floeck

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-0398

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mabelle M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1888

8. AGE: Years 60 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace N. Y. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Bethlehem Steel Corp

FATHER
12. Name Fritz Floeck
13. Birthplace Germany

MOTHER
14. Maiden Name Adelaide Schlauch
15. Birthplace U. S. A.

16 (a) Informant Mrs. Mabelle Floeck
(b) Address 130 N. Eulaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location East, Balto. Co. Md.

18 (a) Funeral director Harry H. Kritzler
(b) Address 410 Edmondson Ave

19 (a) Oct 22 1948 (b) Thonsington Williams, M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20/48 19 , at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 46 to Oct 19 48
and that I last saw h[illegible] alive on Oct 18 19 48

Immediate cause of death: Arteriosclerosis
C.V. disease — Duration 4 yrs

Due to

Due to

Other Conditions Bronchopneumonia — Duration 2 weeks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. F. Fulweiler M. D.
Address 1946 N. Calvert Date signed 10/21/48

PRINCE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

667906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

667906 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: D.O.A.
(a) Baltimore City, Maryland
(b) Street address 338 S. Bentalou
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 338 S Bentalou
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle C Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-7391

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James Bailey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 25, 1909

8. AGE: Years 39 | Months 0 | Days 25 | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation SEWING MACHINE OPERATOR

11. Industry or business BUD COAT Co.

FATHER
12. Name John Brandau
13. Birthplace Maryland

MOTHER
14. Maiden Name Lilley Kromey
15. Birthplace Maryland

16 (a) Informant Mr. James Bailey
(b) Address 121 S. Monroe Street

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 23 1948 (mont (day) (year)
(c) Cemetery or crematory LOUDON PK.
Location 3801 FREDERICK AVE.

18 (a) Funeral director Henry A Wiltse
(b) Address 4101 Edmondson Ave

19 (a) OCT 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20 1948, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-20-48 at 3:30 P. M.
(b). Where did injury occur? 338 S. Bentalou Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury 4 burners and oven on on stove

23. Signature C. J. Pelouse M.D.
Medical Examiner.
Date signed 10/20/48

VS 151

667907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 e

Registered No. 667907

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 623 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JANE M. WARRENBERGER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife George W. Warrenberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 14 1870

8. AGE: Years	Months	Days	If less than one day
78	1	6	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George W. Adams
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Hancock
15. Birthplace Md.

16 (a) Informant Mrs. Etta Harig
(b) Address 714 Frederick Ave., Catonsville

17 (a) Burial (b) Date thereof 10/23/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 22 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20, 1948, at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948, to Oct 20 1948, and that I last saw h[illegible] alive on Oct 1 1948.

Immediate cause of death Intestinal Malignancy — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. J. Tuttleman M. D.
Address 7327 Reisterstown Rd Date signed 10/21/48

VS 150

67908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 67908

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2311 South Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALBERT H. WEIS

3 (b) If veteran, name war:	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ada Baltzley Weis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 30, 1886

8. AGE: Years	Months	Days	If less than one day
62	4	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business U. S. Printing & Lithograph

FATHER
12. Name Louis T. Weis
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret C.
15. Birthplace Baltimore

16 (a) Informant Mr. C. K. Poske
(b) Address 2311 South Rd., Balto. 9, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICHER & SONS
(b) Address Balto., Md.

19 (a) OCT 22 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 19 48 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944 to Oct 16 1948, and that I last saw h[illegible] alive on 10-16 1948

Immediate cause of death: Coronary Thrombosis
Due to: Arteriosclerosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 4 years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Nelson Carey M. D.
Address 1014 St Paul St. Date signed 10-22-48

VS 150

Please see that information should be clearly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. G67909

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 14 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 Thames Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELVEN HARVEY PITTMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife ———

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1909

8. AGE:	Years	Months	Days	If less than one day
EW	39	1	15	hr. min.

9. Birthplace Highlands, N. J.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Pittman
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Grace Johnson
15. Birthplace U. S. A.

16 (a) Informant Mrs. Harry Nyman
(b) Address 331 - 79th St., North Bergen, N. J.

17 (a) Cremation (b) Date thereof 10-23-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Maryland

19 (a) OCT 22 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH October 17, 1948 at 10:25 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull.
Intracranial hemorrhage.
Due to Contusion of brain

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-16-48 at M.
(b) Where did injury occur? Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Fell to ground and struck head during altercation

23. Signature George B. Merrill M.D.
Medical Examiner.
Date signed 10/18/48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67910 ✓ G67910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 061

Registered No. .....

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1002 Rutland Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1002 Rutland Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) ✓

If yes, name country .....

3 (a) FULL NAME Estelle Smith

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Col.	Widow

6 (b) Name of husband or wife Williams

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) Aug 29, 1887

8. AGE: Years	Months	Days	If less than one day
61	1	21	hr. ..... min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business .....

FATHER

12. Name Walter Perry

13. Birthplace N. C.

MOTHER

14. Maiden Name Mary Ann Perry

15 Birthplace D C

16 (a) Informant Walter Smith

(b) Address 1706 E. Eager St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 22/48 (month) (day) (year)

(c) Cemetery or crematory .....

Location Raleigh N. C.

18 (a) Funeral director Mrs. Pott. A. Elliott & Dgt.

(b) Address 1129 N. Gaylord St. Entered Williams, M.D.

19 (a) Oct 1948 (b) ..... Registrar

(Date rec'd by Local Reg.) (Year)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1948 at 6:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3 1948 to 10/20 1948 and that I last saw h alive on 10/20 1948

Immediate cause of death Bronchopneumonia

Due to Diabetes Mellitus

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration 3 dys

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury .....

23. Signature Thos L Lafond M.D.

Address 522 N. Bond St Date signed 10/22/48

67911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1861

Registered No. 67911

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk 22 (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 New Battle grove Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VERNON BERNARD BROWN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1948

8. AGE: Years	Months	Days	If less than one day
	9	6	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER	12. Name	Willie M. Brown
	13. Birthplace	Virginia
MOTHER	14. Maiden Name	Theresa Brown
	15. Birthplace	Maryland

16 (a) Informant Willie M. Brown
(b) Address 110 Newbattle Grove Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location B. B. Co Md

18 (a) Funeral director Isaac L Brown Son
(b) Address 1050 Monty omery St

OCT 23 1948 (Date rec'd by registrar) (b) Washington Wilkinson, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21, 1948, at 8.02 a.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-21-48 at approx. 7.30 a. M.
(b) Where did injury occur? Route 20, Newbattle Grove
(c) Did injury occur at home, on farm, industrial place, in public place? home While [illegible]? no
(d) Means of injury Icebox fell over on head

23. Signature [signature] M.D. Medical Examiner
Date signed October 21, 1948

G67912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67912

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 261 Baltimore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES W. BLANKENSHIP

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Gladys Blankenship

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1903

8. AGE: Years	Months	Days	If less than one day
45	3	29	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Electrician's helper

11. Industry or business

FATHER
12. Name Isaac Stephen
13. Birthplace W. Va.

MOTHER
14. Maiden Name Emma J. Snivley
15. Birthplace Ohio

16 (a) Informant Mrs. Gladys Blankenship
(b) Address 261 Baltimore Ave., Dundalk

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 25, 1948 (month, day, year)
(c) Cemetery or crematory OAK LAWN CEM.
Location 7922 EASTERN AVE.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) OCT 23 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1948, at 8.40 A M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration Cardiac Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edward Rogers M.D. (Medical Examiner)
Date signed October 22, 1948

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

67913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 67913

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5015 Roland Avenue
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County Baltimore
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5015 Roland Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM C. BRISCOE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Sophie Gaither
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr) 9/2/1892

8. AGE: Years	Months	Days	If less than one day
56	1	19	..... hr. ..... min.

9. Birthplace Baltimore, Baltimore, Mary
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John E. Briscoe
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Mary Crawford
15. Birthplace Baltimore, Maryland

16 (a) Informant Patient
(b) Address 5015 Roland Ave.

17 (a) Burial (b) Date thereof 10-23-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ St. John's
Location Ellicott City, Md.

18 (a) Funeral director John O. Whitehill & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (Date rec'd by Local Registrar) OCT 23 1948 Huntington Williams (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1948 at 10:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 8, 1948. to October 21, 1948. and that I last saw him alive on October 21, 1948.

Immediate cause of death Bronchogenic Carcinoma, Rt. Lung — Duration .....

Due to .....

Due to .....

Other Conditions Metastases in liver + pleura
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Glenn P. Grace M.D.
Address Union Memorial Hospital Date signed 10/24/48

VS 159

67914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 Registered No. 67914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 225 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 N. Monroe (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine E. Eigler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife Henry E Eigler, 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18-1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
63	2	3		

9. Birthplace Ellicott City, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name William A Bordeen
13. Birthplace unknown

MOTHER
14. Maiden Name Rachel M. Hatfield
15. Birthplace unknown

16 (a) Informant Henry E. Eigler Jr.
(b) Address 225 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Mausoleum
Location Balto., Md.
18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 OCT 23 1948 (Date rec'd by registrar) (b) Lexington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 - 1948 at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 - 1948 to Oct 21 1948 and that I last saw her alive on Oct. 20 1948

Immediate cause of death Cerebral Hemorrhage — Duration Sept. 5. 1948
Due to Chr. Myocarditis — 1946
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Brown
Address 1663 W. North Av. Date signed 10/21/48 M. D.

VS 130

67915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 67915

Please answer all questions as completely as possible. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3221 Barclay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3221 Barclay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife Isreal Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Middlesex Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Walter Taylor
13. Birthplace Va

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Isreal Smith
(b) Address 3221 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna ave

19 (a) [illegible] Huntington Williams, M.D. Registrar

OCT 28 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1948 at 9 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 15 1948 to Oct 21 1948, and that I last saw h[illegible] alive on Oct 21 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 6 days.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2329 Greenfield Date signed 22 Oct 48

Dr. Swayer
67916

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1314

Registered No. G67916

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2822 Christopher Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2822 Christopher Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Daniel Fisher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Mamie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1872

8. AGE: Years	Months	Days	If less than one day
75	10	26	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation Machinist-Retired
11. Industry or business Crown, Cork, & Seal

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15 Birthplace ?

16 (a) Informant Mrs. Mamie Fisher
(b) Address 2822 Christopher avenue

17 (a) Burial (b) Date thereof 10-25-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenhill Cemetery
Location Waynesboro, Penna

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) OCT 23 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1948 at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1946 to Oct 22 1948 and that I last saw him alive on Oct. 21 1948.

Immediate cause of death: Hypertensive Heart Disease — Duration: 5 years
Due to
Due to
Other Conditions: Chronic nephritis — Duration: 3 years.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Geo. Sawyer M.D.
Address 4808 Harford Rd Date signed 10/22/48

937

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

667917

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164

667917 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: DAVID FRANKLIN BRUCHEY

3 (b) If veteran, name war: War II

3 (c) Social Security Account No. 216-18-7177

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1924

8. AGE: Years	Months	Days	If less than one day
24	1	14	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Balto., Transit

FATHER
12. Name William F. Bruchey
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth B. Metaler
15. Birthplace Balto.

16 (a) Informant: William F. Bruchey
(b) Address 1331 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory New National
Location Balto., Md.

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

19 (a) OCT 23 1948 (Date rec'd by registrar) (b) Funkhouser Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1948 at 9:45PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 21/48 Approx. 9:14 P.M.
(b) Where did injury occur? 1331 W. Pratt
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature [signature] M.D. (Medical Examiner)
Date signed 10/22/48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/a

G67918 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2627 ST. PAUL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 ST. PAUL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LELIA P. TILYARD

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F. M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: JOHN S. TILYARD.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): APRIL 19, 1870
8. AGE: Years 78 | Months 6 | Days 3 | If less than one day hr. min.
9. Birthplace: BALTIMORE (Town, county, and state)
10. Usual Occupation
11. Industry or business: HOME

FATHER
12. Name: JOHN T. RIDDLE
13. Birthplace: MD.

MOTHER
14. Maiden Name: MARY E. WARD.
15. Birthplace: MD.

16 (a) Informant: MRS. MOLLIE T. CAMPBELL
(b) Address: 2622 ST. PAUL ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: OCT. 25, 48 (month) (day) (year)
(c) Cemetery or crematory: LOUDON PARK
Location: BALTO

18 (a) Funeral director: JOHN T. STANSBURY
(b) Address: 2700 EDMONDSON AVE

19 (a) OCT 23 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 Oct 1948, at 7 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 30 1948 to Oct 22 1948 and that I last saw h alive on 19

Immediate cause of death: Coronary Thrombosis
Due to: Senile Arteriosclerosis
Due to:
Other Conditions: Chronic Malnutrition
(Include pregnancy within 3 months of death)

Duration: 10 d.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Carroll Lockard M. D.
Address: 2925 N. Charles St. Date signed: 23 Oct 48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G67919

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93-

Registered No. G67919

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5113 Whitelford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5113 Whitelford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willy Benny

3 (b) if veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minna C. Benny
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 5 1863

8. AGE: Years	Months	Days	If less than one day
85	0	17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Wm Oscar
13. Birthplace Md.

MOTHER
14. Maiden Name Rose Flamm
15. Birthplace Md.

16 (a) Informant Minna C. Benny
(b) Address 5113 Whitelford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location No

18 (a) Funeral director John G. Moran
(b) Address 3000 E. Baltimore St

19 (a) Date received (Registrar) OCT 23 1948 (b) Huntington Nelson (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1948, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Oct 22 1948, and that I last saw h IM alive on Oct 22 1948

Immediate cause of death: Cardio-Vascular Disease — Duration 1 Yr.
Due to: Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Ernest Lucas M. D.
Address 101 N. Rose St. Date signed Oct 23 1948

667920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

667920 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Sol Levi Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 Argyle Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Edward Lucas

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 19, 1921

8. AGE: Years 26 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Balt. Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Harrison Lucas
13. Birthplace Hanover, Va.

MOTHER
14. Maiden Name Lena Ball
15. Birthplace Richmond, Va.

16 (a) Informant Lena Lucas
(b) Address 1220 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory Columbus Memorial Park
Location Balto County Md.

18 (a) Funeral director Chas. H. Sterling
(b) Address 512 Carroll St.

19 (a) OCT 23 1948 (Date rec'd by registrar) (b) Huntington Williamson M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20- 1948, at 6:27 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-[illegible] 1948, to 10-20 1948, and that I last saw h[illegible] alive on 10-20 1948.

Immediate cause of death [illegible] Duration

Due to

Due to

Other Conditions 2 [illegible]

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 10-23-48

G67921

ES-123557

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 53a

G67921 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Genevieve Moutrey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Eugene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6/18/1902

8. AGE: Years	Months	Days	If less than one day
46	4	1	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John H. Jenifer
13. Birthplace Md.

MOTHER
14. Maiden Name Mollie Clark
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk
Location Balto. County, Md

18 (a) Funeral director Charles G. Cr[illegible]r
(b) Address 512 N. Carrollton Ave

19 (a) OCT 23 1948 (Date rec'd by registrar) [illegible] (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19 19 48 at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6- 19 48 to 10-19- 19 48
and I last saw her alive on 10-19 19 48

Immediate cause of death: Sub-arachnoid hemorrhage — Duration 13 d
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. F. Nelson
Address Date signed 10-19-48 M. D.

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G67922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932

Registered No. G67922

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith St
(If rural give location)
(e) Citizen of foreign country? Niesbaden. (Yes or No)
If yes, name country Germany

3 (a) FULL NAME Sr.M;Paterna (Duesel)

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9th. 1880

8. AGE: Years	Months	Days	If less than one day
67	10	13	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business N. D. C. School

FATHER
12. Name George Duesel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Friess
15 Birthplace Baltimore Md.

16 (a) Informant Sr. M. Stan. Kostka.
(b) Address 901 Aisquith. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25th. 48 (month) (day) (year)
(c) Cemetery or crematory Notch Cliff.
Location Glen Arm.

18 (a) Funeral director Geo. M. Fink & Son.
(b) Address 811. N Wolfe. St.

19 (a) Date Rec'd by Registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22nd. 1948, at 1pm M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7th 48 to Oct. 22th 48 and that I last saw her alive on Oct 21st 48

Immediate cause of death: Arteriosclerosis Chr Myocarditis
Due to Cerebral embolus
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis J Kirby Reverend
Address 110 E. North Ave Date signed 10-26-48

V S 150

REGISTRAR'S ATTENTION: Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE WITH UNFADING INK.

G67923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G67923 Registered No. 83a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County
(c) City or town Westown (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 Cottage Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Karl Wohlrab, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 1-1-87

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Glass Factory
11. Industry or business

FATHER 12. Name Karl Wohlrab
13. Birthplace Austria

MOTHER 14. Maiden Name Anna Bower
15. Birthplace Austria

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/23/48 (month) (day) (year)
(c) Cemetery or crematory
Location Westown, W. Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address No. 4 Pa. Aves. Balt 17, Md.

OCT 24 1948 (Date rec'd by registrar)

(b) Tentington Williamsburg

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5- 1948 to 10-23-1948 and that I last saw him alive on 10-23-1948.

Immediate cause of death Cerebrovascular accident — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Gardner M. D.
Address Johns Hopkins Date signed 10/23/48

VS 150

G67924
That

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 441 Registered No. G67924

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Brooklyn #19 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 44th St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edith C. Skoorka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) [redacted] of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-11-23

8. AGE: Years	Months	Days	If less than one day
25	9	12	hr. min.

9. Birthplace NY. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name David Skoorka
13. Birthplace Poland

MOTHER
14. Maiden Name Rosa Leiberman
15. Birthplace Poland

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-48 (month) (day) (year)
(c) Cemetery or crematory
Location New York N.Y.

18 (a) Funeral director Jack Lewis Inc
(b) Address 110 Eutaw Place

19 (a) OCT 24 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23 1948 at 10009 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1948 to 10-23 1948 and that I last saw her alive on 10-23 1948

Immediate cause of death Respiratory Failure — Duration

Due to Bronchial Obstruction

Due to Hodgkins Disease

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B. Crow M.D.
Address Johns Hopkins Hosp Date signed 10-23-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G67925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9rd

G67925 **Registered No.**

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Battery ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Battery ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Padden

3 (b) If veteran, name war — 3 (c) Social Security Account No. 219-14-0175

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/15/1885

8. AGE: Years	Months	Days	If less than one day
62	11	7	hr min

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Bar-Tender

11. Industry or business

FATHER
12. Name Patrick Padden
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kelly
15. Birthplace Ireland

16 (a) Informant Mrs Mamie Padden
(b) Address 1519 Battery ave

17 (a) Burial (b) Date thereof 10/25/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 1848 Light St.

19 (a) OCT 24 1948 (b) Lexington & Williams Sts
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from June 5 1948 to October 22 1948 and that I last saw him alive on Oct 22 1948

Immediate cause of death	Duration
Chronic Endocarditis	6 mos.
Due to — Arteriosclerosis	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O B Mellott M. D.
Address 1279 Williams N Date signed 10/23/48

VS 150

G67926
AB-123597

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 93d

G67926 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 67yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 285 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9-1880

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	✓	✓		

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Henry Williams (D
13. Birthplace West Indies

MOTHER
14. Maiden Name Mary ? (D
15. Birthplace West Indies

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/12/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Loraine Hill Rd

18 (a) Funeral director Tolley Home
(b) Address 318 Light St

19 (a) Lexington Williams, M.D.
(Date rec'd by registrar) Registrar

OCT 14 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11- 1948, at 3.3[illegible] M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-8- 1948 to 10-11- 1948, and that I last saw h[illegible] alive on 10-11- 1948

Immediate cause of death	Duration
Pulmonary Edema	5hr.
Due to: Cardiac failure	2 wk.
Due to: Hypertensive Cardiovascular disease	2-3 yr.
Other Conditions: Bronchopneumonia	2 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. S Stutzman M D
Address Balto. City Hosp Date signed 10-22-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G67927
LCH-108892

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d ✓ G67927 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yrs. 7 mos. 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 242 Laurens Street 17 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME May Ijam — May M. Ijams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife George W Ijams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/6/1859

8. AGE: Years	Months	Days	If less than one day: hr.	min.
89	7	14		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Mitchell
13. Birthplace Md.

MOTHER
14. Maiden Name Cassandra Daniels
15. Birthplace Md.

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Harry Klumpp
(b) Address 4207 Ridgewood Ave

19 (a) Oct 24 1948 (Date received by registrar) (b) Registered No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20/48 (month) (day) at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/4/47 to 10/20/48 and that I last saw her alive on 10/20/48

	Duration
Immediate cause of death Pulmonary embolism	
Due to Questionable Hypertensive arteriosclerotic heart disease & failure	
Due to Phlebothrombosis left leg.	2 mos
Other Conditions Bronchopneumonia Senility (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: [redacted] not done

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature David H. Wagner M.D.
Address Balto City Hosps Date signed 10-23-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any error or information found to be carefully supplied. The

VS 19)

G67928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G67928 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St
(c) Hospital or institution: FRANKLIN SQUARE HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 40 N ELLAMONT ST (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ADOLPH P. KRIEGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) SEPT-24-1880

8. AGE: Years 68 | Months 0 | Days 28 | If less than one day: hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation BUTCHER

11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant OTTO KRIEGER
(b) Address 40 N. ELLAMONT ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10 25 48 (month, day, year)
(c) Cemetery or crematory LORRAINE PARK CEM
Location

18 (a) Funeral director THOMAS J. KENNY INC
(b) Address 1600 HOLLINS ST

OCT 24 1948 (Date received by registrar) by Clayton Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22/48 19 at 5:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from, natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place?
(d) Means of injury

23. Signature John L. Davis, Medical Examiner. M.D.
Date signed 10/23/48

VS 151

B.C. G67929
B.C. 48-2296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G67929
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2
(c) Hospital or institution: Mercy Hospital 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 N. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William John Fitz Gerald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1948

8. AGE: Years	Months	Days	If less than one day
			9 hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Premature

11. Industry or business

FATHER
12. Name Ernest C. Fitz Gerald Jr.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Hazel Mae Albrecht
15. Birthplace Balto. Md.

16 (a) Informant Mother
(b) Address 304 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave

OCT 24 1948 (Date rec'd by registrar)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1948 at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9 A.M. Oct 21 1948 to 3:45 Oct 21 1948, and that I last saw him alive on Oct 21 1948.

Immediate cause of death: Respiratory Failure — Duration

Due to Atelectasis

Due to Prematurity

Other Conditions 5 Mo Pregnancy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which)
(e) Means of injury

23. Signature J. M. Bacon Jr. M. D.
Address Mercy Hospital Date signed 21 Oct 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-123881 G67930

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 932

Registered No. G67930

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 McHenry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Bindeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-20-1874

8. AGE: Years	Months	Days	If less than one day
74	1	1	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Charles Bindeman
13. Birthplace ~~Maryland~~ Germany

MOTHER
14. Maiden Name Agnes Brown
15. Birthplace ~~Maryland~~ Germany

16 (a) Informant Record-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director Charles W. Sackenheimer
(b) Address 703 McHenry St.

19 (a) OCT 24 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21- 1948 at 12.10PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20- 1948 to 10-21- 1948, and that I last saw him alive on 10-21- 1948.

	Duration
Immediate cause of death: Acute myocardial infarction, post.	4 days
Due to: Arteriosclerotic Cardiovascular Disease	
Due to:	
Other Conditions: Cholelithiasis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Vinkes Jr. M.D.
Address Balto City Hosp Date signed 10/26/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B. C. 667931 48-7824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 15a

Registered No. 667931

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: D.O.A
(a) Baltimore City, Maryland
(b) Street address 3804 Woodbine Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Woodbine Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theodore Carl Tatelbaum

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) —

8. AGE: Years	Months	Days	If less than one day
2 mo			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Hyman
13. Birthplace Russia

MOTHER 14. Maiden Name Freda
15. Birthplace Poland

16 (a) Informant Hyman Tatelbaum
(b) Address 3804 Woodbine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-48 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Shirley

18 (a) Funeral director Jack Levin Inc
(b) Address 1100 Eastern Place Huntington Williams, Md

OCT 24 1948 (Date filed by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1948 at 7 40 AM

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hydrocephalus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. E. Schmoke M.D. Medical Examiner.
Date signed 10/24/48

X

VS 151

G67932 3C-48-2321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G67932

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore #17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 N. Hannah St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Bond

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age X years

7. Birth date of deceased (mo., day, yr.) 10-17-48

8. AGE: Years 0 | Months 0 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name James Emory Bond, Jr.
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Felicia Satchell
15. Birthplace Baltimore, Maryland

16. Informant Mother, Felicia Bond
Address 1815 N. Hannah St.

17 (a) ... (Burial, cremation, or removal) **(b) Date thereof** ... (month) (day) (year)

(c) Cemetery or crematory University Medical School OCT 22 1948
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19. OCT 25 1948 (Date received by Registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1948 at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1948 to Oct 19 1948. and that I last saw h alive on 10-17 1948.

Immediate cause of death Atelectasis — **Duration** 24 hrs.

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. A. Reuss M. D.

Address University Hospital Date signed 10-22-48

VS 150

G67933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G67933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3 0th
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34½ hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2137 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William G. Clemmons

3 (b) If veteran, name war

3 (c) Social Security Account No. 225-05-7049

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of ~~husband or~~ wife Margaret Clemmons

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26th 1902

8. AGE: Years 45 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business National Paving Co.

FATHER
12. Name Wm G. Clemmons
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah (Unknown)
15. Birthplace Va.

16 (a) Informant Margaret F. Clemmons
(b) Address 2137 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 OCT 25 1948 (Date rec'd by Registrar) (b) Huntington Millinery, Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23 1948, at 6 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21 1948, to 10/23 1948, and that I last saw him alive on 10/22 1948.

	Duration
Immediate cause of death: Cardio-respiratory failure	1 day
Due to Cerebro-vascular Accident	1½ days
Due to	
Other Conditions Pulmonary edema	1 day

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred H. Dann M. D.
Address Maryland General Hosp. Date signed

VS 180

G67934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G67934

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Calvert & Saratoga

(b) Street address ~~Old Pimlico~~

(c) Hospital or institution:

Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3

(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County BALTO

(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)

(d) Street No. Old Pimlico Rd.
(If rural give location)

(e) Citizen of foreign country? Yes. (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Quincy Warner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife Jeane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5-2-84

8. AGE: Years	Months	Days	If less than one day
64	6	21	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Ephraim ~~Walter~~ Warner

13. Birthplace Pa.

MOTHER 14. Maiden Name Sally Weaver

15. Birthplace Pa

16 (a) Informant Susan Warner (sister)

(b) Address Same

17 (a) Burial (b) Date thereof 10/27/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Druid Ridge

Location Pikesville Md.

18 (a) Funeral director William Cook Inc.

(b) Address 12[illegible] St. Paul St.

19 (a) OCT 25 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23- 1948, at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21- 1948 to 10-23- 1948 and that I last saw him alive on 10-23- 1948.

Immediate cause of death	Duration
Cardiac Failure	
Due to Uremia	
Due to Chronic interstitial nephritis	Months
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Allyn F. Jackson M.D.

Address Mercy Hospital Date signed 10-25-48

VS 150

G67935

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46a Registered No. G67935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 Light St.
(c) Hospital or institution: South Balto. Genl. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 West Bay Cir. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Louise Morris

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-04-1845

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed~~, or divorced: Married
6 (b) Name of ~~husband~~ or wife: Augusta Morris
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 8th 1884
8. AGE: Years 64 | Months 6 | Days 15 | If less than one day: hr min
9. Birthplace: Denmark (Town, county, and state)
10. Usual Occupation: Mill wright
11. Industry or business: Southern Spars Corp.

FATHER
12. Name ?
13. Birthplace Denmark

MOTHER
14. Maiden Name ?
15. Birthplace Denmark

16 (a) Informant: Mrs. Augusta Morris
(b) Address 3708 West Bay Cir

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto. Co., Md.

18 (a) Funeral director Williams Co.
(b) Address 121 E. Saratoga St.

19 OCT 25 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1948, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27, 1948 to Oct 23, 1948, and that I last saw him alive on Oct. 23, 1948.

Immediate cause of death: Empyema, bilateral + mesenteric — Duration: 5 days.
Due to
Due to
Other Conditions: Carcinoma Oesophagus
(Include pregnancy within 3 months of death)

Date of operation Oct. 12, 1948
Major findings of operation: Carcinoma Upper 1/3 Oesophagus
of autopsy: Bilateral empyema + pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams, M.D.
Address 1713 Light Street Date signed 10-25-48

VS 150

110a

G67936

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

× ✓ G67936 55e Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2922 Clearview Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne A
(c) City or town Dorsey (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha M. Heil

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife Philip Heil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1895

8. AGE: Years	Months	Days	If less than one day
53	9	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Smallwood
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Smallwood
15 Birthplace Maryland

16 (a) Informant Philip Heil
(b) Address Dorsey, Maryland

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery or crematory St. Lawrence
Location Jessup, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1948, at 10:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1948 to Oct 22 1948 and that I last saw her alive on Oct 22 1948.

Immediate cause of death	Duration
Lymphosarcoma with Metastases	5 years
Due to	
Due to	
Other Conditions Anemia and Cardiac Failure	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Thomas Brennan M.D.
Address 5217 Harford Road Date signed 10-23-48

VS 150

G67937

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

Registered No. G67937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert St. 3
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 431 E. 27th (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA GARRETTSON.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) AUG 21, 1877

8. AGE: Years	Months	Days	If less than one day
71	2	2	hr. min.

9. Birthplace BALTIMORE, Md (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name EDWARD BOLTON
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name MATILDA ?
15. Birthplace BALTIMORE, Md

16 (a) Informant Edward Garrettson
(b) Address 431 E. 27th st

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 OCT 25 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1948, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1948. to Oct 23 1948. and that I last saw her alive on Oct 23 1948.

Immediate cause of death	Duration
Cerebro Vascular Accident	
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature William E Beaven M. D.
Address Union Memorial Hosp Date signed 10-23-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 159

X

G67938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G67938

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon. Secours Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Ambassador Apt's # 206 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MR. IRVIN G. KROLL

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-0599

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~.
M	W	

6 (b) Name of husband or wife MRS. Ethel Kroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV 14-1894

8. AGE: Years	Months	Days	If less than one day
53	11	10	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Plant Supt
11. Industry or business C & P. Telephone Co.

FATHER
12. Name Adolph Kroll
13. Birthplace Md

MOTHER
14. Maiden Name Annie Gwynn
15. Birthplace Md.

16 (a) Informant Mrs Ethel Kroll
(b) Address Ambassador Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Edmondson Ave.

18 (a) Funeral director Wm Cook Dye
(b) Address 1217 St Paul St

19 (a) OCT 25 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24 1948, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1948 to 10/24 1948, and that I last saw him alive on 10/24 1948.

Immediate cause of death "Cerebral Hemorrhage" "Cerebral vascular accident" — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William S. Womack M.D.
Address Bon Secours Hosp. Date signed 10/24/48

X

667939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832

667939
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7000 W. North St.
(c) Hospital or institution:
Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs. 9 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hooker, Mrs Edith Houghton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Dr. Donald R. Hooker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22-1879

8. AGE: Years	Months	Days	If less than one day
68	10	2	hr. min.

9. Birthplace Buffalo, N.Y.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Alfred A. Houghton
13. Birthplace Buffalo, N.Y.

MOTHER
14. Maiden Name Caroline Gaulinghouse
15. Birthplace Buffalo, N.Y.

16 (a) Informant Records — Wm. Wharton
(b) Address 7000 W. North St. - Balto. Md

17 (a) CREMATION (b) Date thereof 10 25 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory GREENMOUNT
Location BALTO.

18 (a) Funeral director H. W. JENKINS & SONS CO.
(b) Address 4905 YORK RD.

19 (a) OCT 25 1948 (b) Torrington, Williamsville, N.C.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1948, at 2-15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1944 to 10/23 1948, and that I last saw him alive on 10/23 1948

Immediate cause of death	Duration
Bronchopneumonia	3 Days
Due to Hemiplegia (Right)	8 years
Due to Arteriosclerosis (Cerebral)	8 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Sexton Hersperger M. D.
Address 214 Medical Arts Bldg. Date signed 10/24/48

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

667940

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

667940 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 McCulloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1216 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hester Drummond

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1866

8. AGE: Years 82 | Months 5 | Days 6 | If less than one day: hr min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James Bagwell
13. Birthplace Unknown

MOTHER
14. Maiden Name Hester Savage
15. Birthplace Va.

16 (a) Informant Mrs. Ruth Bishop
(b) Address 1216 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1948 at 9:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20-48 19 to Oct 22 1948. and that I last saw h alive on Oct 22-48

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 or 4 hrs.
Due to Senility, debility
Due to Pneumonitis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. N. Cardozo M. D.
Address 524 Druid Hill Ave. Date signed 10-25-48

G67941

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67941
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 minutes
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 E. Overlea Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George Kaltenbach
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Anna Martha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/29/91

8. AGE: Years	Months	Days	If less than one day
57	1	25	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Banking
11. Industry or business

FATHER
12. Name Gottlieb Kaltenbach
13. Birthplace Germany

MOTHER
14. Maiden Name Matilda Christ
15. Birthplace Germany

16 (a) Informant Mrs. George Kaltenbach
(b) Address 13 E. Overlea Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Lancaster Funeral Home
(b) Address 7401 Belair Rd.

19 (a) OCT 25 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1948 at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1947 to Oct 24 1948 and that I last saw h[illegible] alive on Oct 24 1948

Immediate cause of death: Acute Pulmonary Edema — Duration: 2 hrs
Due to Arterio-Sclerotic Heart Disease — 6 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Michael J. Dausch, M. D.
Address 1 W. Overlea Ave Date signed 10/24/48

VS 150

Gatch

667942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131

667942

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert St

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Towson (If outside city or town limits, write RURAL and give town)

(d) Street No. 4 Greenbrier (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Benton R. Gatch

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 216-12-022[illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs. Genevieve Gatch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 27, 1891

8. AGE: Years	Months	Days	If less than one day
57 yrs	1	29	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Vice Pres Paving supply & equipment Co

11. Industry or business

FATHER

12. Name Frank R. Gatch

13. Birthplace Maryland

MOTHER

14. Maiden Name Ellen P. Evans

15. Birthplace Maryland

16 (a) Informant Mrs. Benton R. Gatch

(b) Address 4 Greenbrier Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Baltimore, Md.

18 (a) Funeral director Lassahn Funeral Home

(b) Address 7401 Belair Rd.

19 (a) OCT 25 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1948 at 7:04 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1948 to Oct. 23 1948 and that I last saw him alive on Oct. 23 1948.

Immediate cause of death: Uremia — Duration

Due to Chr. glomerulonephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature John A. Clarson M. D.

Address Union Memorial Hospital Completed 10/24/48

VS 150

67943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 67943

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pennsylvania RR Station
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) transient

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL, and give town)
(d) Street No. 329 Dixie Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HAROLD MORGAN NESS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna Ullrich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1900

8. AGE: Years	Months	Days	If less than one day: hr.	min.
48	7	7		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Vice-President
11. Industry or business Swan Shoe Company, Inc.

FATHER
12. Name Charles Morgan Ness
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sara Frances Wahmann
15. Birthplace Baltimore, Md.

16 (a) Informant: Mrs. Anna U. Ness
(b) Address 329 Dixie Drive, Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month, day, year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John. S. Mitchell-Sons
(b) Address 1900 Eutaw Place, Balto.

19 (a) OCT 25 1948 (Date received) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1948, 12.30a M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? (What was?)
(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed October 24, 1948

VS 181

X

667944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 667944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1814 Maryland Ave

(c) Hospital or institution: 17

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1814 Maryland Ave. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Frederick E. Venerable

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-1892

8. AGE: Years	Months	Days	If less than one day
56	9	23	hr. min.

9. Birthplace Farmville, Va. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name George Venable

13. Birthplace Va

MOTHER 14. Maiden Name Mary Venable

15. Birthplace Va

16 (a) Informant Mable F. Luby

(b) Address 1823 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto. City

18 (a) Funeral director Charles H. Law

(b) Address 802 Madison Ave

19 (a) OCT 25 1948 (Date received by registrar) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21 1948 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/6 1948 to 10/21 1948 and that I last saw h[illegible] alive on 10/21 1948

Immediate cause of death

Central Hemorrhage

Due to Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature B. M. Klutts

Address 3 Dunkirk Rd Date signed 10/25/48

B. M. Klutts X

VS 150

G67945 BC

L48-2024

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. G67945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 6 S. Caroline Street (If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Byrd-Ophelia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 11, 1948

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name George

13. Birthplace Md.

MOTHER

14. Maiden Name Ophelia Moses

15. Birthplace ?

16 (a) Informant B.C.H. Records

(b) Address 4940 Eastern Avenue

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9-16-48 9 AM (month) (day) (year)

(c) Cemetery or crematory B.C.H. crematory

Location 4940 Eastern Ave

18 (a) Funeral director B.C.H. Crematory

(b) Address

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1948, at 10:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 1948 to Sept. 13, 1948, and that I last saw him alive on Sept. 13, 1948.

Immediate cause of death: Prematurity

Duration: 36 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Stat Atelectasis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Williams M. D.

Address BCH Date signed 9-16-48

VS 150

G67946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a ✓ Registered No. G67946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 804 N Chester

(c) Hospital or institution: 7-05

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 804 N Chester (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laurence E Albert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Johanna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29 1865

8. AGE: Years 83 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Asst Drinks Mfg

11. Industry or business retired

FATHER 12. Name John Albert

FATHER 13. Birthplace Va

MOTHER 14. Maiden Name

MOTHER 15. Birthplace

16 (a) Informant Mrs Edna Kirkwood

(b) Address 2217 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25 48 (month) (day) (year)

(c) Cemetery or crematory Balto Cem

Location Balto

18 (a) Funeral director Wm H Ford Funeral Home

(b) Address 2008 Orleans St

19 (a) Date Oct 25 1948 (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1948 at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 48 to Oct 22 19 48.

and that I last saw him alive on Oct 22 19 48.

Immediate cause of death: Acute Dilatation of the Heart — Duration 1 day

Due to: Chronic Myocarditis

Due to:

Other Conditions: Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dr Hugh E Leitch

Address 2323 E Balto Date signed Oct 27 48

VS 150

93d

67947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 ✓

Registered No. 67947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 118 N. Milton Ave.
(c) Hospital or institution: 6-02
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 N. Milton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otto Paul Gregloit

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Edna E. Gregloit
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1881

8. AGE: Years	Months	Days	If less than one day
67	4 3	7	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Penna. R.R.

FATHER
12. Name ---Gregloit
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Edna E. Gregloit
(b) Address 118 N. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Balto., Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

OCT 25 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1948 19 , at M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 18 - 1948 to Oct. 22 - 1948.
and that I last saw him alive on Oct 22 - 1948.

Immediate cause of death
Cardio Vascular Renal
Due to Myocardial Insufficiency
Due to Pulmonary Edema
Other Conditions Acute Cystitis

Duration
5 yrs.
5 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. DiGeyer, M.D.
Address 15 W. Mulberry St. Date signed 10-23-48

VS 150

G67948

476038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ..... (c) L

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 dys

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1701 N. Washington St (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME John C. Rogers (JOHN CLAUDE ROGERS)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-07-2261

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Jane H. Rogers

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr) 11-8-89

8. AGE: Years 58 | Months 11 | Days 15 | If less than one day: hr. ..... min.

9. Birthplace Harford County Maryland (Town, county, and state)

10. Usual Occupation Treater - S. Oil

11. Industry or business Standard Oil Co. N.J.

FATHER

12. Name John Rogers

13. Birthplace Harford County Md.

MOTHER

14. Maiden Name Mary Finney

15. Birthplace Harford County Md

16 (a) Informant MRS. JANE HELEN ROGERS (Wife)

(b) Address 1701 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26. 1948 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem.

Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.

(b) Address Baltimore Md.

19 (a) OCT 25 1948 (Date received) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1948 at 7 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 1948 to 10-23- 1948 and that I last saw him alive on 10-23- 1948

Immediate cause of death: respiratory failure — Duration .....

Due to Carcinomatosis

Due to carcinoma of stomach

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation Oct. 11, 1948

Major findings of operation: Carcinomatosis

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury .....

23. Signature Richard T. Griffith Jr. M.D.

Address Johns Hopkins Hosp. Date signed 10/25/48

VS 150

Ast 6

G67949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G67949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 26

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3523 Clifmont Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua Slaysman (JOSHUA FLAHART SLAYSMAN)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-20-3502

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Pansy Lee Slaysman

6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): 9-29-75

8. AGE: Years: 73 | Months: 0 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation: Watchman

11. Industry or business

FATHER
12. Name: Benjamin Slaysman
13. Birthplace: Md

MOTHER
14. Maiden Name: Maggie Flahart
15. Birthplace: Md

16 (a) Informant: JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) OCT 25 1948 (Date rec'd by Registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

83a

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23- 1948, at 6.05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20- 1948 to 10-23 1948; and that I last saw him alive on 10-23 1948.

Immediate cause of death	Duration
Cerebral vascular accident & Thrombosis in left hemiplegia	
Due to: Generalized arteriosclerosis	
Due to:	
Other Conditions: Diabetes mellitus - mild	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. J. Jackson M. D.
Address The Johns Hopkins Hosp Date signed 10/23/48

G67950

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G67950 Registered No.

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 N. Milton Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 N. Milton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MINNIE FORNOFF

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	none	F	W	Widow

6 (b) Name of husband ~~or wife~~ William Fornoff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 8, 1889

8. AGE: Years	Months	Days	If less than one day
59	0	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Paul schroll
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Schmidt
15. Birthplace Maryland

16 (a) Informant William E. Fornoff - son
(b) Address 508 N. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) OCT 25 1948 (b) Huntington Mills Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 '48 at 3.30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from October 14, 1948 to Oct. 22. 48 and that I last saw her alive on Oct. 22. 1948.

Immediate cause of death: Coronary Artery Occlusion — Duration: ?
Due to
Due to
Other Conditions Hypertension

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 701 N. Kenwood Ave. Date signed Oct. 23. 48

VS 150

G67951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d Registered No. G67951

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 736 Waesche St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 736 Waesche St, (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Truman J. Blake.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Helen Blake
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 29, 1887

8. AGE: Years	Months	Days	If less than one day
61	1	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George W. Blake
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lucinda Snowden
15. Birthplace Md.

16 (a) Informant Helen Blake.
(b) Address 736 Waesche,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Funeral for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1948 at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1948 to Oct 21 1948.
and that I last saw h[illegible] alive on 19

Immediate cause of death Coronary heart failure — Duration 6 mos

Due to Arteriosclerosis

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George McKinnell M. D.
Address [illegible] Date signed 10/21/48

VS 150

Certificate must be filled out with ink. Every item of information must be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G67952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G67952

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 N. Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 01

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 N. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moses Lawson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Ailsie Lawson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 27, 1894

8. AGE: Years	Months	Days	If less than one day
53	9	25	hr. min.

9. Birthplace Harmony, Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Lawson.
13. Birthplace Harmony Va.

MOTHER
14. Maiden Name Ailsie Lawson
15. Birthplace Harmony Va.

16 (a) Informant Ailsie J. Lawson.
(b) Address 511 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26, 1948 (month) (day) (year)
(c) Cemetery or crematory South Boston, Va
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N Lafayette St

19 (a) OCT 25 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1948, at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 19 48 to 10/25 19 48 and that I last saw h alive on 10/25 19 48.

Immediate cause of death — Coronary thrombosis — Duration 5 min.

Due to

Due to

Other Conditions Hypertension and arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Huntington Williams, M.D.
Address Date signed 10/26/48
Ralph W. Eichelberger

VS 130

667953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. 667953

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3106 Presstman St.
(c) Hospital or institution:

16 07

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Presstman St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** ABRAHAM J. ULLMAN.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-5722

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Julia Kann Ullman.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 23, 1878.

8. AGE: Years	Months	Days	If less than one day
70	7	—	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk:-U.S.Government.
11. Industry or business

FATHER
12. Name Jacob Ullman,
13. Birthplace Unknown.

MOTHER
14. Maiden Name Bettie Milheiser,
15. Birthplace Germany.

16 (a) Informant Mrs. Julia K. Ullman,
(b) Address 3106 Presstman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/48. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Blair & Sonnenborn & Son
(b) Address 1902 Eutaw Place.

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Registrar for Williams Bureau

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23rd. 1948 at PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Oct. 23, 1948.
and that I last saw him alive on Oct. 23, 1948.

Immediate cause of death Myocardial Insufficiency — Duration
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature Victor D. Levy M. D.
Address 2322 Eutaw Place. Date signed

VS 150

Medical Examiner's Case 2 be Approved by Chief Medical Examiner

A67954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186

Registered No. A67954

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution: South Baltimore General Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 26 (If outside city or town limits, write RURAL, and give town)

(d) Street No. 1425 Cherry Street (If rural, give location)

(e) Citizen of foreign country? (Yes or No) Yes If yes, name country Burkpfalz Austria

3 (a) FULL NAME FRANK DREXLER

3 (b) If veteran, name war —

3 (c) Social Security Account No —

4. Sex MALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 27 1884

8. AGE: Years 64 Months 5 Days 26 If less than one day: hr. min.

9. Birthplace AUSTRIA (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER

12. Name ALEXANDER DREXLER

13. Birthplace AUSTRIA

MOTHER

14. Maiden Name PAULINE TAUBER

15. Birthplace AUSTRIA

16 (a) Informant HUGO DREXLER

(b) Address 1425 CHERRY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS

Location BROOKLYN MD

18 (a) Funeral director Bernard C Hoehle

(b) Address 434 E WEST ST

19 (a) OCT 23 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1948 at 6 15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 6 55 PM 10-23 1948 to 15 PM 10-23 1948, and that I last saw h[illegible] alive on 10-23 1948

Immediate cause of death Cerebro Vascular Hemorrhage — Duration 5 days

Due to Hypertension Arteriosclerotic 4 years Cardiovascular Disease

Due to

Other Conditions 1) Far Advanced Pulmonary Tuberculosis 2) Excavation Stage of Occp. Right

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

CERTIFICATION APPROVED BY

J. [illegible], M.D.

of autopsy: John R. Brown M.D.

PHYSICIAN: Underline the cause to which death should be charged statistically

22. If death was due to external causes (fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 10 - 19 1948 at [illegible] M

(c) Where did injury occur? Baltimore (City or town) (County) Md. (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?

(e) Means of injury Fall down Steps following Accident

23. Signature Edward C. Newell M.D.

Address 1213 Light Street Date signed 10-23-48

VS 13

932

1679955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 18

Registered No. 1679955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct and is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave and Madison St
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 N. WASHINGTON ST. (If rural, give location)
(e) Citizen of foreign country? N O (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH L SUNSTROM

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	married

6 (b) Name of husband or wife WILLIAM T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/14/61

8. AGE: Years	Months	Days	If less than one day
86	11	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name JAMES J IRWIN
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name JANE WILSON
15. Birthplace BALTIMORE

16 (a) Informant PATIENT
(b) Address 1920 N WASHINGTON ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director C. J. Fenging & Son
(b) Address 1938 E. Lafayette Ave Funeral Home Baltimore, Md.

19 OCT 25 1948 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 1948 at 6 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1948 to 10/22 1948. and that I last saw her alive on 10/21 1948.

Immediate cause of death CEREBRO-VASCULAR ACCIDENT

Duration

CERTIFICATION APPROVED BY Thomas J. Mahoney M.D.

Due to HYPERTENSIVE C.V. DISEASE For Wm. Helfrich, M.D. CHIEF OR ASST. MEDICAL EXAMINER

Due to

Other Conditions FRACT. NECK OF RIGHT FEMUR (Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

Adhesion of pleura overlying of autopsy: Left abdomen.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 8/18/48 at M
(c) Where did injury occur? BALTO. 13 MD (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME While at work? NO (Specify type of place)
(e) Means of injury FELL WHILE WALKING

23. Signature Paul G Herold M.D.
Address Maryland Gen Hosp Date signed 10/22/48

93L To be approved by coroner's office

CERTIFICATE CORRECTED 9-1-50

667956 M.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1330 Registered No. 667956

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2009 Rayner Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Wallace

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Sep.

6 (b) Name of husband or wife Ernest
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1905

8. AGE: Years	Months	Days	If less than one day
43	2	26	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name Edgar Vessells.
13. Birthplace VA.

MOTHER
14. Maiden Name Emma ?
15. Birthplace VA.

16 (a) Informant B.C.H.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Laurence A. Holland
(b) Address 1631 Druid Hill Ave

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 19 48 at 6:40 P.M.

21. I certify that death occurred on the day above stated, that I attended deceased from July 8 19 48 to Oct. 22 19 48 and that I last saw her alive on Oct. 22 19 1948

Immediate cause of death uremia — Duration

Due to Chronic pyelonephritis

Due to

Other Conditions Hypertension Heart failure.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David H. Marine M.D.
Address Balto City Hosp. Date signed 10-23-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 K

Registered No. 67957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600
(c) Hospital or institution: MARYLAND GEN. HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mos 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 828 N. BENTALOU #6 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country —

3 (a) FULL NAME Howlett OSBORN / SIMMONS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband/wife IDA H. Simmons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 26, 1879

8. AGE: Years	Months	Days	If less than one day
69	7	27	hr. min.

9. Birthplace BALTIMORE Md. (Town, county, and state)
10. Usual Occupation retired MERCHANT MARINE
11. Industry or business Inspector; U.S.C.G.

FATHER
12. Name OSBORN SPRIGG SIMMONS
13. Birthplace [illegible] A. A. Co.

MOTHER
14. Maiden Name IDA J. BLAKE
15. Birthplace [illegible] Matthews Va.

16 (a) Informant WIFE IDA
(b) Address SAME AS DECEASED

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 OCT 1948 at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 01 OCT 1948 to 23 OCT 1948, and that I last saw HM alive on 23 OCT 1948.

Immediate cause of death	Duration
CARDIORESPIRATORY FAILURE	6 HOURS
Due to HODGKINS DISEASE	1½ YRS
Due to	
Other Conditions CHRONIC BRONCHITIS HYPERTROPHIC ARTHRITIS ARTERIOSCLEROSIS (Antecedent causes. Morbid conditions of death)	

Date of operation
Major findings of operation:
Co. of autopsy: PERMIT REFUSED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald F. England M. D.
Address Maryland Gen. Hosp. Date signed 25 OCT 48

VS 150

667958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d ✓ 667958

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4506 Sorrento Ave.

(c) Hospital or institution: Colonial Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3118 Gwynns Falls Pkwy. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN B. HUDSON

3 (b) If veteran, name war no

3 (c) Social Security Account No.

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Emma Margaret Hudson nee Hummel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1862

8. AGE: Years 86 | Months 2 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Providence, R. I. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business A. & P.

FATHER

12. Name Frank Hudson

13. Birthplace Ireland

MOTHER

14. Maiden Name Mary McCusker

15 Birthplace Boston

16 (a) Informant Mr. Henry J. Hudson

(b) Address 3118 Gwynns Falls Pkwy.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/27/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 25 1948 (Date rec'd by registrar) **(b)** Huntington-Wells Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1948, at 7:15a M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 1 1948 to Oct 24 1948, and that I last saw h alive on Oct 23 1948.

Immediate cause of death Pulmonary Oedema, Hypostatic pneumonia, Myocarditis

Due to Cerebral arterio Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Robert E. Kotsch M.D.

Address 2151 Wilkens Ave **Date signed** Oct 24/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 159

667959

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170 c Registered No. 667959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
UNION Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 05
(e) Length of stay in Baltimore (yrs., mos., or days) 17

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 31 E. 21st. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACKSON WHEAT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Marie L. Wheat

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Chas. O. Wheat
13. Birthplace Md.

MOTHER
14. Maiden Name Bessie Edwards
15. Birthplace Va.

16 (a) Informant Nathaniel S. Wheat (Uncle)
(b) Address 912 Keyser Bldg. (F10244)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 25 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 23, 1948, at 7:38 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of Skull & Intracranial Hemorrhage

Due to

Other Conditions Fracture of Pelvis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 22/48 1:50 A.M.
(b) Where did injury occur? Charles & 21st. St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Struck by auto

23. Signature Emil H. Rogge M.D.
Medical Examiner
Date signed 10/23/48

VS 151

G67960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 77C

Registered No. G67960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 01
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 W. Lee Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: William A. Gregory

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20th, 1894

8. AGE: Years 54 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace: Maryland
Seaman (Ward, county, and state)

10. Usual Occupation: Arundel Sand Co.

11. Industry or business

FATHER
12. Name: (Unknown) Gregory
13. Birthplace: "

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Florence Ferger
(b) Address 309 N. Monastery Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-48 (month, day, year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director Wm Cook Sons
(b) Address 1217 St Paul St.

19 (a) OCT 25 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1948 at 1:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Aorta Aneurism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify)
(d) Means of injury

23. Signature Emil H Rogge M.D.
Medical Examiner.

Date signed 10-25-48

A-667961

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 22yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3230 Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24- 1873

8. AGE: Years	Months	Days	If less than one day
75	4	13	hr. min.

9. Birthplace Poughkeepsie, N.Y. (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name David Myers
13. Birthplace N.Y.

MOTHER
14. Maiden Name Cecelia Malcox
15. Birthplace N.Y.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St.

18 (a) Funeral director Wm Cook Co.
(b) Address 12 17 St Paul St.

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7- 1948 at 8,45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4- 1930 to 10-7 1948.
and that I last saw h er alive on 10-7 1948.

Immediate cause of death Chronic nephritis — Duration ?

Due to

Due to

Other Conditions Hypertensive Cardio Vascular disease — Years

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman J Cole MD M.D.
Address 4940 Eastern Ave Date signed 21 Oct 48

G67962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 ✓

Registered No. G67962

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2411 N. Pulaski St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 24
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 N. Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Fava

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Mamie Fava

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 3rd 1884

8. AGE: Years 64 | Months 5 | Days 21 | If less than one day: hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Manufacturer

11. Industry or business Vincenzi Macaroni Co

FATHER
12. Name Joseph Fava
13. Birthplace Italy

MOTHER
14. Maiden Name Joanna M. Gazzo
15. Birthplace Italy

16 (a) Informant Mrs. Mamie Fava
(b) Address 2411 N. Pulaski St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10-28-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 S. Paca St.

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Registrar Thurston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1948, at 1 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1948 to Oct 24 1948, and that I last saw him alive on Oct 23 1948.

Immediate cause of death
Carcinoma of Stomach
Secondary Involvement
Due to Coronary Thrombosis
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)

Duration
2 mos
1 mo
—
—
mo

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature [illegible] Wilkins M.D.
Address 3 E. Read St Date signed Oct 25 1948

X

VS 150

667963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓

Registered No. 667963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) she said while bringing her upstairs and putting her to bed
(e) Length of stay in Baltimore (yrs., mos., or days) 4 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 501 Wildwood Pk'way (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Anna Jones Annie

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife A. Jones.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 24 - 1880

8. AGE: Years 68 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Bloecher
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Dehmen
15. Birthplace Germany

16 (a) Informant Mr A. Jones
(b) Address 501 Wildwood Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Geo K Berger Jr
(b) Address 1512 Hollins St

19 (a) Date received by registrar OCT 25 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24/ 1948, at 10.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1948, to 19 .
and that I last saw her alive on 10/24 1948.

Immediate cause of death Heart failure

Duration

Due to Coronary Thrombosis

Due to Hypertension

Other Conditions

CERTIFICATION APPROVED BY

(Include pregnancy within three months of death)

Date of operation

Major findings of operation

of autopsy:

Emil Pfeiffer M.D.
CHIEF OF ASST. M.E.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William S. Womack M.D.
Address Bon Secours Hosp. Date signed 10/24/48

VS 150

667964 Vsl 2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93 d ✓ Registered No. 667964

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 - 3
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 Mount St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3 (a) FULL NAME Walter Hillery

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Lucille

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr) 6-19-07

8. AGE: Years 41 | Months 4 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Thomas Hillery
13. Birthplace Md

MOTHER 14. Maiden Name Rebecca Clark
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address .....

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pressman St

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1948 at 400 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1948 to 10-21 1948 and that I last saw him alive on 10-21 1948.

Immediate cause of death Pulmonary edema. — Duration 5 days.

Due to Coronary Occlusion Heart failure Hypertensive Arteriosclerotic Heart Disease. Uremia, anuria.

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: Pulmonary Edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan Calkins M.D.
Address .....
Date signed 10/24/48

VS 150

667965

JL - 123804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. 667965

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals 70 ot

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3109 Leeds St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sue Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1900

8. AGE: Years	Months	Days	If less than one day
48	8	14	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Jesse Anderson

13. Birthplace ?

MOTHER

14. Maiden Name Sarah Napper

15. Birthplace Va.

16 (a) Informant B.C.H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/26/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location md

18 (a) Funeral director George L. Kelson

(b) Address 1303 Pleasant St

19 (a) OCT 25 1948 (b) Name and address of physician Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1948, at 3.50 PM.

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 16. 1948, to Oct. 22 1948, and that I last saw her alive on Oct. 22 1948

Immediate cause of death Hypertensive cardiovascular disease

Duration 1 Month

Due to Cardiac failure

Due to Hypertension

Duration 3 years +

Other Conditions azotemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature David N Marcus M. D.

Address Balto City Hosp. Date signed 10-25-48

VS 150

0667966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 0667966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Saint Joseph's Hosp/

(c) Hospital or institution: 8.06

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1726 N. Wolfe Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Hines Jr.

3 (b) If veteran, name war W.W. #I

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/20/1893

8. AGE: Years	Months	Days	If less than one day
55	3	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Stock Clerk

11. Industry or business A. Hoen And Co.

FATHER

12. Name Frank Hines Sr.

13. Birthplace Md.

MOTHER

14. Maiden Name Pauline C. Oppel

15. Birthplace Md.

16 (a) Informant Family

(b) Address 3709 Fifth Street

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Ritchie Highway

18 (a) Funeral director James L. McCauley

(b) Address 130 East Fort Avenue

19 (a) OCT 26 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23/ 1948, at 8 26 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19- 1948 to 10/23 1948, and that I last saw h— alive on 10/21 1948.

Immediate cause of death	Duration
Coronary Vascular disease	1 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. Weiss, MD M. D.

Address 1927 E. North Ave Date signed 10-26-48

VS 150

67967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44 N Registered No. 67967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Chapel Gate Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Reisner Elizabeth M. Reisner

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife W. Francis
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Mar. 7 1885

8. AGE: Years	Months	Days	If less than one day
63	5	16	hr. min

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Henry J. Freund
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine R. Reichert
15. Birthplace Balto

16 (a) Informant W. Francis Reisner
(b) Address 423 Chapel Gate Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4600 Belair Rd

18 (a) Funeral director Dippel Bros.
(b) Address 7610 Belair Rd

19 (a) Oct 25 1948 (b) Received by registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1948, at 5:40 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 25 1948, to Oct. 25 1948, and that I last saw h alive on 19

Immediate cause of death	Respiratory failure	Duration
Due to	Cerebral Hemorrhage	
Due to	Brain Cytoplasma	
Other Conditions (Include pregnancy within 3 months of death)		

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. C. Hamlin M.D. M. D.
Address University Hospital Date signed Oct 27 1948

VS 150

G67968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67968 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1025 William St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 William St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nora Eckhardt

3 (b) If veteran, name war: 0000

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or ~~wife~~ Howard Eckhardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1876

8. AGE: Years	Months	Days	If less than one day
72	3	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Lilly
13. Birthplace N. J.

MOTHER
14. Maiden Name Sarah E. Fortner
15. Birthplace Md.

16 (a) Informant Mr. Howard Eckhardt
(b) Address 1025 William St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.A.Co., Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.

19 OCT 25 1948 (Date rec'd by registrar) Registrar Washington Co. Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1948 at 12.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 19 Oct 24 19 48. and that I last saw her alive on Oct 23 19 48.

Immediate cause of death	Duration
Pernicious anemia (Right Hemiplegia	1 month
Due to Stag Horn Kidney	2 years
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 122 E. Clarke St. Date signed 10 Oct 48

VS 150

667969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164 L

667969 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3841 Clifton Ave.
(c) Hospital or institution: West Balto. Gen. Hosp. (OOA)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-09
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3841 Clifton Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul William Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-22-6037

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Rose C. Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1880

8. AGE: Years 68 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired - Civil Service

11. Industry or business

FATHER
12. Name Karl Thomas
13. Birthplace Germany

MOTHER
14. Maiden Name Lena
15. Birthplace Germany

16 (a) Informant Mrs. Rose C. Thomas
(b) Address 3841 Clifton Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10-26-48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 OCT 25 1948 (Date rec'd by registrar) (b) Twentington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Oct. 1948 at 3 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushing Injury of Chest, Bilateral

Due to Fall

Other Conditions Cataracts, bilateral Both eyes
(Include important conditions within 3 months of death) Suspondelosis

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 23 Oct 48 at 2:30 P. M.
(b) Where did injury occur? Clifton Ave. Bridge
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work?
(d) Means of injury Fall from bridge

23. Signature Wm. H. Hammond, Jr. M.D. Medical Examiner.
Date signed 23 Oct. 48

VS 151

G67970

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G67970 Registered No. 1312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 - Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 years

2. USUAL RESIDENCE OF DECEASED:
(a) State ... County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 953 - Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, divorced Married

6 (b) Name of husband or wife Fletcher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. ? 1893

8. AGE: Years 55 | Months 8 | Days ? | If less than one day hr. min.

9. Birthplace Va. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business ?

FATHER
12. Name
13. Birthplace Va.

MOTHER
14. Maiden Name Sweet Lounck
15. Birthplace Va

16 (a) Informant Fletcher Lewis
(b) Address 953 - Penna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-48 (month) (day) (year)

(c) Cemetery or crematory
Location Mt. Calvary

18 (a) Funeral director A. Warfield
(b) Address 918 - Druid Hill Ave.

19 (a) 10-25-1948 (Date rec'd by registrar) Tennington Wallace, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22 1948, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7-1948 to 10-22-1948, and that I last saw her alive on 10-22-1948

Immediate cause of death Mitral insufficiency pulmonary edema — Duration

Due to Essential hypertension & hypertensive cardio-renal disease

Due to

Other Conditions Pneumonia, Influenza TB Pulmonalis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature

Address Date signed 10-25-48 M. D.

VS 133

X

G67971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

G67971
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 11-04
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 McCulloh Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROGER LAWRENCE THOMAS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	married

6 (b) Name of husband or wife Myrtle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. ? , 1904

8. AGE: Years	Months	Days	If less than one day
44	9	-	hr. min

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Helper on truck
11. Industry or business

FATHER
12. Name ? Thomas
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Mary Annells
15. Birthplace Washington, D.C.

16 (a) Informant: Myrtle Thomas
(b) Address 1326 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)
(c) Cemetery or crematory
Location Mount Calvary

18 (a) Funeral director A. Halsteadt
(b) Address 918 Druid Hill Ave.

19 (a) [illegible] (Signature of registrar) Edrington Williams, M.D.
(b) Date received by registrar [illegible]

VS (51)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1948, at 7.20 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocarditis
Heart Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? (While at work?)
(d) Means of injury

23. Signature Earl L Royster M.D. (Medical Examiner)
Date signed October 24, 1948

X

G67972

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

G67972 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1139 N. Mount St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 03
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1139 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA REVELL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-12-1861

8. AGE: Years	Months	Days	If less than one day
86	10	10	hr. min.

9. Birthplace Exmure, Virginia (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Custus Revell
13. Birthplace Virginia

MOTHER
14. Maiden Name Rosa James
15. Birthplace Virginia

16 (a) Informant Anna Revell
(b) Address 1139 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 Carrollton Ave.

19 (Date rec'd by registrar) OCT 25 1948 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1948, at 12.01 AM

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. (Medical Examiner.)
Date signed 10/22/48

G67973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G67973 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 S. Oldham
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 S. Oldham (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Raymond Clay Yost

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No. 214-01-7373

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 8, 1909

8. AGE: Years	Months	Days	If less than one day
39	8	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Canning work
11. Industry or business Tomato Canning Co.

FATHER
12. Name John Yost
13. Birthplace Baltimore

MOTHER
14. Maiden Name Marie Yaeger
15. Birthplace Baltimore

16 (a) Informant Lewis Yost
(b) Address 615 S. Oldham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location 6 Mile Cor.

18 (a) Funeral director Thos. A. Connelly
(b) Address 4[illegible] Eastern Ave. East Huntington Williams, Md.

25 1948 Date rec'd by registrar

Registrar

VS 152

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Oct. 1948, at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Oct. 1948, to 22 Oct. 1948 and that I last saw him alive on 22 Oct. 1948.

Immediate cause of death: Coronary Occlusion — Duration: 2 hrs.
Due to
Due to
Other Condition

CERTIFICATION APPROVED BY
[illegible] M.D.
for John R. Davis M.D.
CHIEF OR ASST. MEDICAL EXAMINER

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. Kay Mowen M. D.
Address 1407-D Nickenbocker Rd Date signed 9/29/48

X Camp Md.

G67974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55d

Registered No. 3974

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1708 Eutaw Place

(c) Hospital or institution: Elmhurst Nursing Home 1703

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8½ mo.

(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2627 Calvert St
(If rural give location)

(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME William Brandt

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) UNKNOWN

8. AGE: Years	Months	Days	If less than one day
84	—	—	hr. min.

9. Birthplace UNKNOWN.
(Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant DAVID MELHAUSER

(b) Address 610 LENNOX ST. BALTO. 17

17 (a) CREMATION (b) Date thereof OCT. 25, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory GREENMOUNT

Location GREENMOUNT AND NORTH AVES.

18 (a) Funeral director Walter Burke Bradley

(b) Address 1922 W. North Ave.

19 (a) OCT 26 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 October 1948, at 10 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1948 to Oct. 23 1948. and that I last saw him alive on Oct. 23 1948.

Immediate cause of death	Duration
generalized carcinomatosis.	
Due to CA - nose - began - with extensive destruction	
Due to nose & adjacent sinuses	
Other Conditions Destruction present when entered Elmhurst Nursing Home	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: Hemorrhagic Chronic Sclerosis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Louis Sparks

Address 1708 Eutaw Pl. Date signed Oct 25 1948
M. D.

VS 150

G67975 12-48-1879

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1195 Registered No. G67975

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 1720 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Charles Shifflet

3 (b) If veteran, name war
3 (c) Social Security Account No. ✓

4. Sex male
5. Color or race white
6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-27-48
8. AGE: Years | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Noah Shifflet
13. Birthplace Va.

MOTHER
14. Maiden Name Ruby Dykes
15. Birthplace Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gerson Hill Road

18 (a) Funeral director Lilly & Zeh-Lee
(b) Address 403 N. Eutaw St

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntingtown, Maryland Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1948, at 9:15 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1948 to 10/24 1948, and that I last saw him alive on 10/24 1948

Immediate cause of death	Duration
Intestinal Hemorrhage	
Due to Diarrhea ? Dysentery	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Ryan M. D.
Address JHH. Date signed

X

G67976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1175

Registered No. G67976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 133 N. Highland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs BESSIE-E. NELSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Bernard Nelson
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 5-10-93

8. AGE: Years	Months	Days	If less than one day
55	5	15	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name James H Bradley
13. Birthplace Balto Md

MOTHER
14. Maiden Name Lilly Matthews
15. Birthplace W-Va.

16 (a) Informant Husband
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto

18 (a) Funeral director Jos J Stevenson
(b) Address 3021 Kentucky ave

19 (a) OCT 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1948, at 2:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28-1948 to 10-25-1948, and that I last saw her alive on 10-25-1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Gastric hemorrhage	
Due to Duodenal ulcer	? months
Perforation	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10-16-48
Major findings of operation: Perforating duodenal ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allyn E. Jones M.D.
Address Mercy Hospital Date signed 10-26-48

VS 150

X

G67977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G67977 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5008 Liberty Heights Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Blanche Gore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, (widowed) or divorced: Widowed

6 (b) Name of husband or wife Edward Gore

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1877

8. AGE: Years 71 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Philadelphia, PA. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John C. Hook
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Susan Hutton Hooton
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Carroll A. Hook
(b) Address 5008 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27, 1948 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore, Md.

18 (a) Funeral director Willis Lamoreaux
(b) Address 4820 Liberty Heights Ave.

19 (a) (Date received by registrar) (b) Washington Millimans, M.D.

OCT 29 1948

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1948, at 12:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 1948 to Oct. 24 1948, and that I last saw her alive on Oct. 24 1948.

Immediate cause of death: Heart Failure — Duration

Due to Myocardial Infarct

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Post. Myocardial Infarct

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Chaney Decker M. D.
Address Women's Hospital Date signed 10-29-48

X

667978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93C

Registered No. 667978

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4700 Harford Road

(c) Hospital or institution: 10

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 710 East Biddle St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ann Leland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Thos Leland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1878

8. AGE: Years	Months	Days	If less than one day
70	9	1	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Daniel O'Sullivan

13. Birthplace Ireland

MOTHER

14. Maiden Name Elizabeth Mc'lister

15. Birthplace Ireland

16 (a) Informant Bernard O'Sullivan

(b) Address 710 East Biddle St

17 (a) Burial (b) Date thereof Oct. 26, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 900 East Biddle St

19 (Date rec'd by registrar) OCT 25 1948 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Oct. 1948 at 12.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Oct. 1948 and that I last saw her alive on 20 Oct. 1948.

Immediate cause of death: Chronic Hypertrophic Arthritis — Duration: 20 yrs.

Due to

Due to

Other Conditions Arteriosclerotic Cardio Vascular Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Wm. A. Kamman, J.

Address 5015 Sheridan Ave Date signed 25 Oct. 48

VS 150

667979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No. 667979

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 01
(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daniel Schaffer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W.

6 (b) Name of husband or wife Jennie Burpes
6 (c) If alive, give age / years

7. Birth date of deceased (mo., day, yr) June 6 1872

8. AGE: Years	Months	Days	If less than one day
76	4	17	hr. min.

9. Birthplace Dellan Pa (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Adam Schaffer
13. Birthplace

MOTHER 14. Maiden Name Kath. Hooper
15. Birthplace

16 (a) Informant Lillie Sines 7 Fe Pa
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St.

19 (a) Oct 25 1948 (Date received by local registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1948 at 4-a. M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1 1948, to Oct 23 1948, and that I last saw him alive on Oct 22 1948.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Hypertensive Cardio	
Due to Vascular Disease	1 yr
Other Conditions Arterio Sclerosis	10 Yr.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)
(e) Means of injury

23. Signature E Gale Hall M.D.
Address 1631 E North Ave Date signed 10/23/48

VS 150

667980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 H

Registered No. 667980

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 21 N Carey St
(a) Baltimore City, Maryland
(b) Street address 444 Monroe St
(c) Hospital or institution: Geo Edmonton Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 1 1 0

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County
(c) City or town 444 Monroe St
(If outside city or town limits, write RURAL and give town)
(d) Street No. ..... (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Aileen Carr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 33 | Months Any | Days 1 | If less than one day: hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name Robert Carr
13. Birthplace Pa

MOTHER
14. Maiden Name Lillie Clark
15. Birthplace Maryland

16 (a) Informant Robert Carr
(b) Address 632 E 28th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co

18 (a) Funeral director Wm P Jackson
(b) Address 916 Penna Ave

19 [illegible] 25 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21/48 19 ..., at 7 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/3/48 to 10/21/48 and that I last saw her alive on 10/20/48.

Immediate cause of death: Intestinal Obstruction — Duration: 1 week

Due to Cancer uterus & metastases — Duration: unknown

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter F Sowers

Address 402 Edmondson Ave Date signed 10/27/48

VS 150

X

Dr. Wm. Hospital
1700 Eutaw Pl.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 667981

667981

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertie A. Myers

3 (b) If veteran, name war

3 (c) Social Security Account No. 231-05-5738

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Arthur Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1880

8. AGE: Years	Months	Days	If less than one day
68	2	17	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business New Vogue Cleaners

FATHER
12. Name L. A. Hall
13. Birthplace Virginia

MOTHER
14. Maiden Name ?
15. Birthplace Virginia

16 (a) Informant Ruth Craighead
(b) Address 1700 Eutaw Place

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 10/25/48 (month) (day) (year)
(c) Cemetery or crematory Sherwood
Location Roanoke, Virginia

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

OCT 25 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1948 at 4:30 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1948 to Oct 25 1948
and that I last saw him alive on Oct 22 1948

Immediate cause of death	Duration
(a) Carcinoma of Intestinal Tract	one year
Due to (b) Carcinoma	
Other Conditions Carcinoma	

(Include pregnancy within three months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?
(e) Means of injury

23. Signature Wm Cook M. D.
Address 1217 Eutaw Pl. Date signed 10/25/48

VS 150

T 467982

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

XV 1272

Registered No. 467982

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Woodbine RURAL
(If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John U. Fink Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Infant

6 (b) Name of husband or wife
6 (c) If alive, [illegible] age years

7. Birth date of deceased (mo., day, yr.) Oct 12 - 48

8. AGE: Years | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Poplar Spring Md
(Town, county and state)

10. Usual Occupation [illegible]
11. Industry or business

FATHER 12. Name John J. Fink
13. Birthplace Balto Md

MOTHER 14. Maiden Name Anna Belli
15. Birthplace Balto

16 (a) Informant John L. Fink
(b) Address Kay. Co

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Ly Motor Co
(b) Address E. Fayette

19 (Date rec'd by registrar) OCT 25 1948 Huntington Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1948 at 11:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 10-11 1948 to 10-24 1948, and that I last saw him alive on 10-24 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10-14-48
Major findings of operation: Cholycystotomy Duodenostomy done
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Holloway M. D.
Address University Hospital Date signed 10-24-48

VS 15J

G67983
ES-78979

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

0 13 G67983 Registered No.

LEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Salvation Army
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Lurz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Sep.

6 (b) Name of husband or wife Antonia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 23, 1879

8. AGE: Years	Months	Days	If less than one day
69	0	29	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Lurz
13. Birthplace Md.

MOTHER
14. Maiden Name Wilhimina Schulten
15. Birthplace Holland

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director J. J. Luck
(b) Address 5305 Harford Rd.

19 (a) (Date received by Registrar) OCT 25 1948 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22 1948 at 9:15 M

21. I certify that death occurred on the date above stated, that I attended deceased from 1-5-43 to 10-22 1948 and that I last saw him alive on 10-22 1948

Immediate cause of death: Hemorrhage from lungs — Duration: 2 days
Due to: For advanced bilateral pulmonary tuberculosis — 2 yrs (?)
Due to:
Other Conditions: Generalized arteriosclerosis — yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret A. Morgan M. D.
Address Baltimore City Hosp Date signed 10-24-48

YS 150

X

G67984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 G67984 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 47

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Bayonne Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence B. Cannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife James L. Crawford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9-1883

8. AGE: Years 65 Months 5 Days 14 If less than one day hr. min.

9. Birthplace Fredericksburg, Va. (Town, county and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Henderson

FATHER 13. Birthplace

MOTHER 14. Maiden Name

MOTHER 15. Birthplace

16 (a) Informant Mr. James A. Cannon

(b) Address 3711 Bayonne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)

(c) Cemetery or crematory Morland Pk

Location Dulaney Valley Rd.

18 (a) Funeral director Lucke

(b) Address 5305 Harford Rd.

OCT 25 1948 (Date rec'd by registrar)

(b) Christopher Witt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 OCT 1948 at 9.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 OCT 1948 to 23 OCT 1948. and that I last saw h alive on 19

Immediate cause of death CARDIORESPIRATORY FAILURE — Duration 24 hours

Due to PRIMARY ATYPICAL PNEUMONIA — 6 DAYS

Due to

Other Conditions DIABETES MELLITUS CORONARY SCLEROSIS

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation AUTOPSY PLEURAL EFFUSION FIBRINOUS PERICARDITIS CORONARY SCLEROSIS

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald S. England M. D.

Address Maryland Gen. Hosp. Date signed 23 Oct 48

109a

VS 150

G67985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G67985
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5719 Ridgedale Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 ---
(e) Length of stay in Baltimore (yrs., mos., or days) 88 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5719 Ridgedale Road
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Annie B. Melis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr) Jan. 30, 1860

8. AGE: Years	Months	Days	If less than one day
88	8	25	-- hr. -- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name Martin Melis
13. Birthplace Germany

MOTHER
14. Maiden Name Magdalena Bachner
15. Birthplace Germany

16 (a) Informant Mrs. Stanley Belcher
(b) Address 5719 Ridgedale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director H. W. Weaver and Son
(b) Address 805 N. Calvert Street

OCT 25 1948 (Date rec'd by registrar) Kensington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1948, at 9.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1948 to Oct 24 1948 and that I last saw ... alive on Oct 24 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 wks
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel H. Belcher M. D.
Address 5611 Timber Rd Date signed 10-27-48

VS 350

G67986

ES-123667

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

956 G67986 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: Balto. city hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2567 Arunah Ave. (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME: ~~Marie Jeffries~~ MARIE C. JEFFREY

3 (b) If veteran, name war ******

3 (c) Social Security Account No. ********

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leroy Jeffrey

6 (c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr): Jan. 11, 1900

8. AGE: Years 48 | Months 10 | Days 12 | If less than one day ******** min.

9. Birthplace: Md. Baltimore (Town, county, and state)

10. Usual Occupation: housewife at

11. Industry or business: home

FATHER
12. Name: George Whatmough
13. Birthplace: England

MOTHER
14. Maiden Name: Lilly Lloyd
15. Birthplace: Md.

16 (a) Informant: RECORDS-BALTO. CITY HOSPITALS
(b) Address: 4940 EASTERN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 26/48 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 13000 EUTAW PLACE..17

OCT 25 1948 (a) (b) (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22- 1948 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 1948 to 10-22 1948, and that I last saw her alive on 10-22 1948.

Immediate cause of death: Cardiac failure — Duration: 6 mos

Due to: ? Rheumatic heart Dis — 1 year

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Rickbold M. D.
Address Balto City Hosp. Date signed 10-25-48

G67987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67987
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 EDGEWOOD STREET
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Pulaski Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country NO.

3 (a) FULL NAME JAMES H. BROWN

3 (b) If veteran, name war ******* | 3 (c) Social Security Account No. *******

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Sarah Brown
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr) Dec. 24-1868

8. AGE: Years	Months	Days	If less than one day
79.	10	--	hr. min.

9. Birthplace Harrington Delaware (Town, county, and state)
10. Usual Occupation Motorman - Retired
11. Industry or business Baltimore Transit Co.

FATHER
12. Name John Henry Brown
13. Birthplace Delaware

MOTHER
14. Maiden Name Clemintine Harrington
15. Birthplace Delaware

16 (a) Informant Mrs. Olive B. Griffiss
(b) Address 406 Edgewood Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26/48 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey Maryland

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Place...17

OCT 25 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1948, at 2 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1948 to Oct 23 1948. and that I last saw him alive on Oct 23 1948.

Immediate cause of death	Duration
Cardio vascular - nephritis	several yrs.
Due to Uremia -	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W B Carman M.D.
Address 2200 Guilford Blvd Date signed 10-25-48

VS 150

G67988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G67988 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): less than 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): less than 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Westminster (If outside city or town limits, write RURAL, and give town)
(d) Street No.: Route 5 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: EARL "C" MORTON

3 (b) If veteran, name war: WW I & WW 2

3 (c) Social Security Account No.: --

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Esther Howard Morton

6 (c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Aug. 1, 1894

8. AGE: Years: 54 | Months: 2 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Jacksonville NC (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Coast Guard

FATHER
12. Name: Leonard Morton
13. Birthplace: NC

MOTHER
14. Maiden Name: Emma Mason
15. Birthplace: NC

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28-48 (month) (day) (year)
(c) Cemetery or crematory: Meadow Branch
Location: Carroll Co

18 (a) Funeral director: H Bankard & Son
(b) Address: Westminster Md

19 (a) Oct 28 1948 (b) Registrar: Hunting for Williams M.D. Registrar

VS 139

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 25 1948 at 4:35A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24 1948 to Oct. 25 1948, and that I last saw him alive on Oct. 25 1948.

Immediate cause of death: Ruptured jejunal diverticulum and peritonitis — Duration: 18 hrs.

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Jr. Surgeon M. D.
Address: Clinical Director Date signed: 10/25/48

667989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 93d

667989 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or Institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 1yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 22 (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Lerman Hill Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Bulko

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Florence Edith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 2, 1893

8. AGE: Years	Months	Days	If less than one day
55	6	23	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Painter and Paperhanger
11. Industry or business Self employed

FATHER
12. Name Andrew Bulko
13. Birthplace —

MOTHER
14. Maiden Name Mary —
15. Birthplace —

16 (a) Informant Mrs. Florence Bulko.
(b) Address 207 Lerman Hill Rd. Balto 22 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Shawsheen, Pa.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1948. at 5:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from October 23 1948 to Oct 25 1948 and that I last saw him alive on Oct 23 1948

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	7 hrs
Due to (b) Hypertensive Cardio-Vascular Disease	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ray E. Pearre Jr. M.D.
Address St. Josephs Hosp. Date signed 10/25/48

X

667990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 C

667990 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3203 Dillon Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) n/k

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3203 Dillon Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY ANNA DOBIHAL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or ~~wife~~ John Dobihal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29th, 1885

8. AGE: Years	Months	Days	If less than one day
62	9		hr. min.

9. Birthplace unknown (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Kahl

FATHER 13. Birthplace unknown

MOTHER 14. Maiden Name "

MOTHER 15. Birthplace "

16 (a) Informant Mr. John Dobihal

(b) Address Greenhaven, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Oak Hill

Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.

(b) Address 2601-3-5 E. Madison Street

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1948, at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1945, to Oct 23 1948, and that I last saw h~~er~~ alive on Oct 22 1948.

Immediate cause of death	Duration
Generalized Arteriosclerosis	
Generalized Hypertensive arterial	
Due to Chronic Myocarditis	Nov 1945
Myocardial Failure	Oct 2/48
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? None (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify home, farm, etc.) While at work?

(e) Means of injury

23. Signature Ed Schimunek M. D.

Address 942 S. Eastlake Date signed 10-25-48

G67991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 561

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Druid Hill Ave & Rayner Ave
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Cambridge (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Jennie Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife William R. Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 26, 1893

8. AGE: Years	Months	Days	If less than one day
55	9	29	hr. min.

9. Birthplace Fredonia, N. Y. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name August T. Groll
13. Birthplace Fredonia, N. Y.

MOTHER
14. Maiden Name Augusta Hildebrant
15. Birthplace Fredonia, N. Y.

16 (a) Informant William R. Thomas
(b) Address R. F. D. Cambridge, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Spedden
Location R.F.D. Cambridge, Md.

18 (a) Funeral director Granville LeCompte
(b) Address Cambridge, Maryland.

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1948 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1948 to Oct 25 1948, and that I last saw h-er alive on Oct 25 1948.

Immediate cause of death Cardiorespiratory arrest

Due to Brain Tumor

Duration: 3 wks (?)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct 23, 1948

Major findings of operation: Same as above

of autopsy:

over

PHYSICIAN
(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel Silverstein M. D.
Address West Balto Gen. Hosp. Date signed 10/25/48

VS 150

667992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

667992 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1920 W. Saratoga St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 70
(e) Length of stay in Baltimore (yrs., mos., or days) Life Time

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel H. Hamburger

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Emma R. Hamburger nee Stumpner
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 1, 1868
8. AGE: Years 80 | Months 1 | Days 25 | If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Bottle industry

FATHER
12. Name John Hamburger
13. Birthplace U. S.

MOTHER
14. Maiden Name Fanny Harman
15. Birthplace U. S.

16 (a) Informant Mrs Cora Shaffer
(b) Address 1920 W. Saratoga St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Edmondson Ave. Balto. Md.
18 (a) Funeral director John O. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place
19 (a) OCT 26 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 166

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1945, at 11:40 a M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1945 to Oct 24 1945; and that I last saw him alive on Oct 24 1945.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Benjamin Hader M. D.
Address 2306 Eutaw Pl Date signed 10-26-45

67993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 5-a

67993 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2436 N Charles St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2436 N Charles St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Cary Pearson

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-03-0802

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: (none) Single

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Sept-30-1880

8. AGE: Years 68 | Months 0 | Days 24 | If less than one day: hr. ____ min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business Elite Restaurant (9 yrs)

FATHER 12. Name Thomas G. Pearson

FATHER 13. Birthplace probably Balto Md.

MOTHER 14. Maiden Name Mary Russell

MOTHER 15. Birthplace probably Balto Md.

16 (a) Informant Miss Avondale N. Gordon (friend)

(b) Address 2436 N Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-27-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md.

18 (a) Funeral director Stuart Mc Guire Co.

(b) Address 108 W Mount Ave

19 (a) OCT 26 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1948, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1948 to Oct 24 1948, and that I last saw h~~e~~r alive on Oct 23 1948

Immediate cause of death: Carcinoma of Mediastinum

~~Due to~~ Carcinoma of Ovary

Due to Generalized metastases.

Duration: Known 3 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul H. Clough

Address 24 E. Eager Street Date signed Oct 25

VS 150

667994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 667994

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1411 Cairo St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Cairo St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Georgie Foster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30. 1892

8. **AGE:** Years: 56 Months: 5 Days: 23 If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Thomas Blake

13. Birthplace unknown

MOTHER 14. Maiden Name Margaret Blake

15. Birthplace G. A. Co. Md

16 (a) Informant Eugene Blake

(b) Address 25 K. St. N.E. Washington D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26 48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem

Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Belnord Ave

19 OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 48 19 at 10 M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 16 48 19 to Oct 23 48 19, and that I last saw h alive on Oct 23 48

Immediate cause of death	Duration
Acute Myocarditis	1 week
Due to Mass up abdomen	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilm A Foster M.D.

Address 1411 Cairo St Date signed Oct 25 48

VS 150

x 29

67995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

67995 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. Fremont Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-6681

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	widowed

6 (b) Name of husband or wife Adele

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1887

8. AGE: Years	Months	Days	If less than one day: hr.	min.
61	4	8		

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Agnes Williams
15. Birthplace Maryland

16 (a) Informant Ethel Scott
(b) Address 122 N. Fremonth Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month, day, year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 Carrollton Ave.

19 OCT 26 1948 (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1948, at 11.30 PM

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
A.S.C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify which)
(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed October 24, 1948

VS 151

G67996

478742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G67996

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5626 Loch Raven, Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Isaac Norris, Sr.

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edna V. Norris

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) July 18, 1880

8. AGE: Years 68 | Months 3 | Days 6 | If less than one day: hr. min.

9. Birthplace Md. (Balto.) (Town, county, and state)

10. Usual Occupation Retired - Vice President

11. Industry or business Bradford Fed. Sav. & Loan Asso.

FATHER
12. Name Francis Norris
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Stevens
15. Birthplace Balto. Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 – 1948 at 11:50 PM ~~12:15 AM~~

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 24 1948 to Oct. 24 1948 and that I last saw him alive on Oct. 24 1948

Immediate cause of death: myocardial infarction — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. S. Tickner

Address Johns Hopkins Date signed 10/25/48 M. D.

G67997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No. G67997

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Linden Ave & Madison St
(c) Hospital or institution: Maryland Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 dys
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1441 N. BENTALOU ST (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME HAMILTON W ROUSE

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 214-26-5228

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: EDNA E. ROUSE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 25, 1894

8. AGE: Years 54 | Months 3 | Days 0 | If less than one day: hr. min.

9. Birthplace: BALTIMORE (Town, county, and state)

10. Usual Occupation: Coal & Fuel Dealer

11. Industry or business: Benson Fuel Corp.

FATHER
12. Name: FRANCIS W. ROUSE
13. Birthplace: BALTIMORE

MOTHER
14. Maiden Name: HANNAH JANE BRUNNER
15. Birthplace: BALTIMORE

16 (a) Informant: EDNA E. ROUSE (WIFE)
(b) Address: 1441 N. BENTALOU ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (d) OCT 26 1948 (Date rec'd by registrar) (Transcription for Williams M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Oct 1948, at 6 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1948, to 10/25 1948, and that I last saw h[illegible] alive on 10/25 1948.

Immediate cause of death: CARCINOMATOSIS OF LIVER — Duration

Due to

Due to

Other Conditions: CIRRHOSIS OF LIVER

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: CARCINOMA OF LIVER

of autopsy: CARCINOMA OF LIVER

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: E. C. Crosson M. D.
Address: Md. Gen'l Hosp Date signed 10/25/48

VS 150

667998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 667998

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2403 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM BOEHM

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Agnes Boehm nee Sieber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Apr. 28, 1869

8. AGE: Years	Months	Days	If less than one day
79	5	26	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Farmer

FATHER
12. Name Unknown
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Unknown
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Anna Bailey
(b) Address 2403 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1948 at 1:50p M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17, 1948 to Oct 24 1948, and that I last saw h[illegible] alive on Oct 23 1948

Immediate cause of death Coronary Thrombosis. — Duration

Due to

Due to

Other Conditions Senility.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.
Address 820 Medical Arts Bldg Date signed 10/26/48

VS 150

X

667999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 667999

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4803 York road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4803 York road
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE M. MESKILL

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife Edmund J. Meskill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1874

8. AGE: Years	Months	Days	If less than one day
74	5	2	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Martin Conner
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Murray
15. Birthplace Ireland

16 (a) Informant Edmund Meskill
(b) Address 4803 York road

17 (a) Burial (b) Date thereof 10/28/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. G. Evans Sons Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) OCT 26 1948 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1948 at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Oct 24 1948.
and that I last saw her alive on Oct 24 1948.

Immediate cause of death Hypertensive cardio Vascular disease

Due to

Due to

Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Louis T. Lavey M. D.

Address 1844 W. Baltimore Date signed 10/25/48

136

G63000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G63000

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2736 Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2736 Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Georgina Meyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Julius Meyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 - 1867

8. AGE: Years	Months	Days	If less than one day
81	4	21	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Peter C. Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Hoeniger
15. Birthplace Germany

16 (a) Informant Mrs. Edna L. Meyer.
(b) Address 2736 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location

18 (a) Funeral director Chas. P. Towell
(b) Address 2727 Edmondson Ave

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1948, at 11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1948 to Oct 24 1948.
and that I last saw h[illegible] alive on Oct 24 1948.

Immediate cause of death	Duration
Coronary occlusion	
Myocardial failure	
Due to Arteriosclerosis	
Cardiovascular disease	
Due to Senility	
Other Conditions Bronchitis and Emphysema, congestion of lungs	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1802 Hayward Rd Date signed 10/26/48

V S 150

8001

BC-48-25207

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G68001 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 South Eutaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Owen Patrick Mills WILLS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 21, 1948

8. AGE: Years	Months	Days	If less than one day
		5-4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Owen Patrick Willis
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annette Marie Muir
15. Birthplace Ellwood City, Pa.

16 (a) Informant Mother
(b) Address Same as above

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT 26 1948 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD.
18 (a) Funeral director DIPPEL BROTHERS
(b) Address 1800 E LOMBARD ST.
19 (a) OCT 26 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25, 1948, at 5½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1948, to 10-25 1948, and that I last saw him alive on 10-25 1948.

Immediate cause of death	Duration
Anoxia	
Due to Respiratory Failure	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ben Bodi M. D.
Address University Hospital Date signed 10-25-48

PLEASE WRITE IN INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G68002

BALTIMORE CITY HEALTH DEPARTMENT ✓ 54b Registered No. G68002

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 315-S. Caton Ave.
(c) Hospital or institution:
20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315-S. Caton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEROY T. MARSH.

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White. | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Sadie M. Marsh.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July. 11-1903.

8. AGE: Years 45 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation Former —

11. Industry or business Quality Beef Co.

FATHER
12. Name Harry T. Marsh.
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Bessie Crapp.
15. Birthplace Carroll Co. Md.

16 (a) Informant Mrs. Sadie M. Marsh
(b) Address 315-S. Caton Ave.

17 (a) Burial. (b) Date thereof Oct. 27-'48.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512-Frederick Ave.

19 (Date rec'd by registrar) OCT 26 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

29. DATE OF DEATH October, 24 1948, at 10.40 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1948 to Oct 24 1948. and that I last saw him alive on Oct 23 1948.

Immediate cause of death Tumor of Brain (Carcinomatosis) Duration

Due to Metastasis

Due to

Other Conditions Pulmonary Oedema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hubert C. Mitchell M. D.
Address 251 Wilkens Ave Date signed 10/25/48

V S 150

G68003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G68003

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2814 Taney Rd.
(c) Hospital or institution: 4 or

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 317 N. Greene Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angelina Marsiglia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation ~~Housewife~~
11. Industry or business

FATHER
12. Name Angelo Sciuto
13. Birthplace Italy

MOTHER
14. Maiden Name Cimino
15. Birthplace Italy

16 (a) Informant Anthony Marsiglia
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27-1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4430 Old Frederick Road

18 (a) Funeral director Joseph Farace Inc.
(b) Address 2013 Guilford Ave

OCT 26 1948 (Date rec'd by registrar) Huntington for Williams, M.D. Registrar

VE 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1948 at 5 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from September 22 1948 to October 25 1948 and that I last saw her alive on Oct 17 1948:

Immediate cause of death Bronchopneumonia — Duration

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Siscanke, M.D.
Address 1429 W Fayette St Date signed 10/25/48

G68004

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68004 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Provident Hosp.
(c) Hospital or institution: 1517 Division St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Argyle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theodore Pinder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Alice A. | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1875

8. AGE: Years 73 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Centerville, Md. (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

MOTHER | FATHER
12. Name Edward Pinder
13. Birthplace Maryland
14. Maiden Name Mary A. ?
15. Birthplace Maryland

16 (a) Informant Mrs. Alice A. Pinder
(b) Address 1208 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Location Baltimore, Md.

18 (a) Funeral director Mrs. George T. A. Gibson
(b) Address 1735 Druid Hill Ave.

19 (a) Oct 26 1948 (Date received by Local Registrar) (b) Huntington (Baltimore) Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24/48 19 . at 9:2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27/48 to 10/24/48 and that I last saw him alive on 10/24/48

Immediate cause of death: Carcinoma of Stomach
Due to: & metastasis to liver & Pancreas
Other Conditions: resonal bypass Nov. 10.
(Include pregnancy within 3 months of death)

Duration

Date of operation 10/2/48
Major findings of operation: same as above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Adelcone M. D.
Address 1131 Harlem Ave. Date signed 10/25/48

VS 150

G68005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 Registered No. G68005

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 5 0
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Hillen St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME PETER JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1893

8. AGE: Years 55 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Peter Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Sallie Fowlkner
15. Birthplace Va.

16 (a) Informant Hayward Johnson
(b) Address Virgilina Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County

18 (a) Funeral director Mrs. Robt. A. Elliott & Daugh.
(b) Address 1129 N. Caroline St.

19 (a) OCT 26 1948 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1948, at 10:45 P M

21. I certify that I took charge of the remains described above, held an Insp. & Ing. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weaver M.D. Medical Examiner.
Date signed 10/22/48

VS 151

X

G68006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77C

Registered No. G68006

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J. McClain.

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1920

8. AGE: Years: 28 | Months: 6 | Days: 8 | If less than one day: hr. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: Zorah ?
15. Birthplace: North Carolina

16 (a) Informant: Wilma Breeden
(b) Address: 1226 N. Caroline St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-26-48 (month) (day) (year)
(c) Cemetery or crematory
Location Dunn, N. Carolina

18 (a) Funeral director: Mrs. Robt. A. Elliott & Dot.
(b) Address: 1129 N. Caroline St.

19 OCT 26 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1948, 10.50 P.M.

21. I certify that I took charge of the remains described above, held an AUTOPSY thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema
Cerebral edema

Due to Acute alcoholism

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl C. Rogers M.D. Medical Examiner.
Date signed October 24, 1948

G68007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No. G68007

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0
(e) Length of stay in Baltimore (yrs., mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1834 N. Duncan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Flickinger Zentz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Irma H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16-1897

8. AGE: Years	Months	Days	If less than one day
51	9	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Ice C.
11. Industry or business

FATHER
12. Name Franklin Zentz
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Flickinger
15. Birthplace Md.

16 (a) Informant Mrs. Irma Zentz
(b) Address 1834 N. Duncan

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Balto

18 (a) Funeral director J. J. Leuck
(b) Address 5305 Harford Rd.

19 OCT 26 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Oct. 1948 at 12 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 25 Oct. 48

VS 131

Dr. Gordy
668008

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
83a

Registered No. 668008

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4900 Walther Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 4900 Walther Blvd. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Mary C. Kratz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1880

8. AGE: Years	Months	Days	If less than one day
68	4	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Conrad Kratz
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Bing
15. Birthplace Md.

16 (a) Informant Mrs. Marie Northrup
(b) Address 4900 Walther Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)
(c) Cemetery or crematory Jeruselem Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) OCT 26 1948 (Date received by registrar) Washington, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1948, 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1948 to Oct 24 1948.
and that I last saw her alive on Oct 15 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 18 days
Due to Hypertension — 10 years
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: no
of autopsy: no

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury none

23. Signature L. F. Gordy M.D.
Address 5106 Harford Road Date signed 10/25/48

VS 150

G68003 Hospital Dispersal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G68005

Prem. 2 Cr 48-2302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 N. Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Seward

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-21-48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Irving Seward
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 OCT 26 1948 Thurlington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1948, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1948, to 10-22 1948, and that I last saw him alive on 10-22 1948.

Immediate cause of death Atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Young M. D.
Address Johns Hopkins Hosp Date signed 10-23-48

VS 150

G68010

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 65B

G68010
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 E. Lorraine Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS MARY AGNES BUNN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Albert T. Bunn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1881

8. AGE: Years	Months	Days	If less than one day
67	8	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name James Cleary
13. Birthplace —

MOTHER
14. Maiden Name Anna Mara
15. Birthplace —

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Cath

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount Ave & 22nd.

19 (a) OCT 26 1948 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mond. Oct. 25 1948, at 1 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1948 to Oct 25 1948, and that I last saw her alive on Oct 25 1948.

Immediate cause of death	Duration
Peripheral vascular collapse	2 hrs
Due to Septicemia with probable hemorrhage	
Due to arts adrenale	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: see above

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Bowen, M.D.
Address Mercy Hospital Date signed 10-25-48

G68011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164 F

Registered No. G68011

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univeristy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne A
(c) City or town Dorsey, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Ohio Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IRMA M. LITTLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John G. ~~[illegible]~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1918

8. AGE: Years 30 | Months 5 | Days 2 | If less than one day: hr. min.

9. Birthplace Dorsey, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Claude F. Dunkerly
13. Birthplace Baltimore Co., Md.

MOTHER
14. Maiden Name Mary E. Litchfield
15. Birthplace Baltimore Co., Md.

16 (a) Informant Mr. Claude F. Dunkerly
(b) Address Ohio Avenue, Dorsey, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1028-48 (month) (day) (year)
(c) Cemetery or crematory Zion Cemetery
Location Dorsey, Maryland

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins Street

19 (a) OCT 26 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1948, at 7 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry Partial autopsy. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, ~~suicide~~ ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Compound fracture of ~~[illegible]~~

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-25-48 at Approx. 6:15 P. M.
(b) Where did injury occur? Dorsey, Maryland
(c) Did injury occur at home, on farm, in ~~[illegible]~~ place, in public place? R. R. Prop. While at work? No
(d) Means of injury Jumped in front of train

23. Signature [signature] M.D. Medical Examiner.
Date signed 10-26-48

668012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668012 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address #33[illegible] CALVERT ST.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE.
(c) City or town BALTIMORE. (If outside city or town limits, write RURAL and give town).
(d) Street No. 3008 E KESWICK RD. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT EARNEST CLAGGETT.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife MINNIE CLAGGETT
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr) NOV 8 1870

8. AGE: Years	Months	Days	If less than one day
77	11	15	hr. min.

9. Birthplace MARYLAND. (Town, county, and state)
10. Usual Occupation GARDNER.
11. Industry or business

FATHER
12. Name LUTHER CLAGGETT.
13. Birthplace MARYLAND

MOTHER
14. Maiden Name JOHANNA WATKINS
15 Birthplace MARYLAND.

16 (a) Informant MILDRED STINCHCUM
(b) Address 923 HOLLEN RD, BALT Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27-1948 (month) (day) (year)
(c) Cemetery or crematory Bethesda
Location Brookeville, Montgomery Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 OCT 26 1948 (Date rec'd by registrar) Huntington Williamsport

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT 24 1948, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from OCT 23 1948 to OCT 24 1948, and that I last saw him alive on OCT 24 1948.

Immediate cause of death Cerebro vascular Accident — Duration

Due to Arteriosclerotic Cardio vascular Disease

Due to

Other Conditions Nephro sclerosis, chronic

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William E. Brown M. D.
Address Union Memorial Hosp Date signed 10-24-48

668013

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668013 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 N. Stricker St
(c) Hospital or institution: 1901
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 N. Stricker St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Edna Perkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Pickens Perkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1885

8. AGE: Years: 63 | Months: 6 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Edgefield, S.C. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Aaron Mathis
13. Birthplace: Edgefield, S.C.

MOTHER
14. Maiden Name: Rose
15 Birthplace: Edgefield, S.C.

16 (a) Informant: Lucy Smith
(b) Address: 411 N. Stricker.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27, 1948 (month) (day) (year)

(c) Cemetery or crematory: Mt. Calvary
Location

18 (a) Funeral director: Mrs Katie R. Williams
(b) Address: 322 N Schroeder St.

19 (a) OCT 26 1948 (Date rec'd by registrar) Huntington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1948 at 9.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-19-1948 to Oct 22 1948, and that I last saw h[illegible] alive on Sept 18 1948.

Immediate cause of death: Valvular Heart Disease — Duration: 1

Due to: Hypertension — Duration: 7

Due to — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas Sheppard
Address 904 N Fulton Ave Date signed 10/23/48 M.D.

VS 180

G68014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68014 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 872 W. Fayette St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Same

(If outside city or town limits, write RURAL and give town)

(d) Street No. 872 W. Fayette St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Winder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Laura Winder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1877

8. AGE: Years: 71 | Months: 8 | Days: 20 | If less than one day: hr. min.

9. Birthplace Morgan Mo. (Town, county, and state)

10. Usual Occupation House Man

11. Industry or business

FATHER 12. Name George A. Winder

13. Birthplace Md.

MOTHER 14. Maiden Name Louise Kelly

15. Birthplace Md.

16. (a) Informant Laura Winder

(b) Address 872 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 27, 1948 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Memorial

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) Oct 26 1948 (Date received by Registrar) Registrar (b) Number for Williams Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1948 at 2 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 15 1948 to Oct 22 1948

and that I last saw [illegible] alive on Oct 22 1948.

Immediate cause of death: Ac. Nephritis

Due to: Uremia

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed Oct 26 48

VS 150

G68015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G68015

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18-0 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Arlington Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Harris

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Mary Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 6 1917

8. AGE: Years 30 | Months 11 | Days 18 | If less than one day hr. min.

9. Birthplace Augusta, Ga. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Anna Belle McCallum
(b) Address 708 Vine Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28 1948 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cem.
Location

18 (a) Funeral director Mrs Rafter R. Williams
(b) Address 32 N. Schroeder Str

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 15

20. DATE OF DEATH October 23, 1948, at 8: p. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of lungs and heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-23-48 at Approx. 8 P. M.
(b) Where did injury occur? Josephine & Pine Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Firearms

23. Signature Emil Kyz M.D. Medical Examiner.
Date signed 10-24-48

VS 151

G68016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68016 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Shell Bank Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Cherry Hill (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Shell Bank Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Jefferson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thomas Jefferson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 16, 1893.

8. AGE: Years: 54 | Months: 10 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Belton, S.C. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: James Smith.
13. Birthplace: S.C.

MOTHER
14. Maiden Name: Ola Greer
15. Birthplace: S.C.

16 (a) Informant: John Jefferson.
(b) Address: 1212 Shellbank Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 29, 1948 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location:

18 (a) Funeral director: Mrs Katie R. Williams
(b) Address: 322 N. Schroeder St

19 (a) OCT 26 1948 (Date received by registrar) (b) Huntingtown, Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1948 at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1948 to Oct 23 1948. and that I last saw her alive on Oct 23 1948.

Immediate cause of death: Endocarditis

Due to: Cardiac Asthma

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration (unknown)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, industrial place)
(e) Means of injury
23. Signature C. M. Lawrence M. D.
Address 1033 W. Lanvale St Date signed 10-20-48

VS 150

G68017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G68017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3011 Garrison Boulevard
(c) Hospital or institution: 15 DS
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3011 Garrison Boulevard (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Garrison
13. Birthplace Lith

MOTHER
14. Maiden Name Kuchner
15. Birthplace Lith

16 (a) Informant Sarah Davis
(b) Address 3011 Garrison Boulevard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Reisterstown Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1400 Eutaw Place

19 OCT 26 1948 (Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1948, at 1 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to Oct. 1948, and that I last saw him alive on Oct 23, 1948.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. T. Lisansky M.D.
Address 7210 Liberty Heights Ave Date signed 10/26/48

VS 150

G68018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G68018

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 Nortonia Road
(c) Hospital or institution: The Mount 15 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2629 Loyola Northway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 51 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Sales Lady

11. Industry or business

FATHER
12. Name Hessel
13. Birthplace Russia

MOTHER
14. Maiden Name Rose
15. Birthplace Russia

16 (a) Informant Louis Goldberg
(b) Address 2629 Loyola Northway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)
(c) Cemetery or crematory Loudale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 760 Eutaw Place

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Timothy for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25-1948 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1948 to Oct 21 1948, and that I last saw h[illegible] alive on Oct 21 1948.

Immediate cause of death: Cancer of the cervix of the uterus — Duration: 3½ yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Shapiro M.D. M. D.
Address 5106 Park Heights Ave Date signed 10/26/48

VS 150

668019

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

940 ✓ Registered No. 668019

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4200 Pall Mall Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophia Soypher (Zoypher)

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Benjamin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years: 78 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county and state)
10. Usual Occupation: House Work
11. Industry or business

FATHER
12. Name: Morris Joseph
13. Birthplace: Russia

MOTHER
14. Maiden Name: Rebecca
15. Birthplace: Russia

16 (a) Informant: husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-48 (month) (day) (year)
(c) Cemetery or crematory Rodaker
Location Hamilton Ave. Post Rd

18 (a) Funeral director Jack Levi Inc
(b) Address 1100 Eutaw Pl

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1948, at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1948, to 10-25 1948, and that I last saw her alive on 10-25 1948.

Immediate cause of death: myocardial infarction — Duration:
Due to coronary insufficiency
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roger Strauss M. D.
Address Sinai Hosp. Date signed 10-25-48

VS 150

68020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a ✓

Registered No. 68020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto General

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

3 (a) FULL NAME Louis A Cavalier

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or
Male	White	Married

6 (b) Name of husband or wife Esther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
67	4		hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER	12. Name Not Known
	13. Birthplace Russia
MOTHER	14. Maiden Name Not Known
	15. Birthplace Russia

16 (a) Informant Esther Cavalier
(b) Address 3800 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date there 10-27-48 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Druid Hill Road

18 (a) Funeral director Jack Levy Inc
(b) Address 216 Eutaw Place

19 (a) OCT 26 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1948, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1945 to Oct 25 1948, and that I last saw him alive on Oct 25 1948.

Immediate cause of death Coronary Thrombosis. — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. P. Young M.D.
Address West Balto Gen. Hosp. Date signed Oct 26

VS 150

(68) 1220 N Charles 21

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 ✓ Registered No. 668021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 724 Berry St
(c) Hospital or institution: 1307

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 Berry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret L Lentz
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Levi B.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 14 1871
8. AGE: Years 77 | Months 9 | Days 11 | If less than one day hr. min.
9. Birthplace Carroll Co Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Koontz
13. Birthplace unknown

MOTHER
14. Maiden Name Smith
15. Birthplace unknown

16. (a) Informant Mrs Marie Stitt
(b) Address 724 Berry St

17 (a) Burial (Burial, cremation, removal) (b) Date thereof Dec 28-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Md

18 (a) Funeral director Frank H Lentz
(b) Address 814 N 26 St

19 (a) OCT 26 1948 (Date rec'd by regist(rar)) (b) Registrar for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1948 at 7A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1948 to Oct. 25 1948. and that I last saw h[illegible] alive on Oct. 24 1948

Immediate cause of death	Duration
Bronchopneumonia	10 days
Due to Carcinoma of Breast	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Gerardi
Address 1500 N. Charles St Date signed Oct 26 1948

VS 150

EC-LP-23057

668022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160 C

Registered No. 668022

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 70 Min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 6,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4230 Seidel Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Santmyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-48

8. AGE: Years | Months | Days | If less than one day hr. 70 min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Robert Gill Santmyer
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Emily Margarette Erskine
15. Birthplace Baltimore Maryland

16 (a) Informant Mr. Robert Santmyer
(b) Address 4230 Seidel Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 26 1948 (Date filed by Registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH 10-25 1948 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25-1948 to 10-25-1948, and that I last saw her alive on 10-25-1948.

Immediate cause of death: cardiac failure — Duration

Due to premature separation of placenta

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Bon Secours Hosp Date signed 10/27/48 M D

VS 150

G68023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G68023

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos. or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town [BALTIMORE] Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 Melvin Ave.
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME John A Rose

3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edna E. Rose
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 9/19/1878

8. AGE: Years 70 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Canada (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Deceased (John Rose)
FATHER 13. Birthplace Scotland

MOTHER 14. Maiden Name Deceased (Susan Talbot)
MOTHER 15. Birthplace Nova Scotia

16 (a) Informant Mrs. Edna E. Rose
(b) Address 118 Melvin Ave, Catonsville

17 (a) Cremation (b) Date thereof 10/27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 26 1948 (b) Huntington Williams, M.D. Registrar
(Registered by registrar)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25/48 19[48] at 6:40 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10/25 1948 to 10/25 1948 and that I last saw him alive on 10/25 1948

Immediate cause of death Coronary Occlusion — Duration

Due to Generalized Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Coronary occlusion

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert J. Lenicka
Address St. Agnes Hosp. Date signed 10/25/48 M.D.

Herbert J. Lenicka

G68024

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164a

G68024 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 11-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 Bolton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES JAMESON SKINNER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 087-12-8371

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Anna G. Skinner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1883

8. AGE: Years	Months	Days	If less than one day
65	9	11	hr. min.

9. Birthplace: Scotland (Town, county, and state)
10. Usual Occupation: Chief Engineer
11. Industry or business: Maritime Commission

FATHER
12. Name: Charles Skinner
13. Birthplace: Scotland

MOTHER
14. Maiden Name: Mary Forsyth
15. Birthplace: Scotland

16 (a) Informant: Mrs. Anna G. Skinner
(b) Address: 1203 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month, day, year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 26 (Date rec'd by registrar) (b) 6 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25/48 19 , at 8:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Strangulation

Due to:

Other Conditions: Marked depression

(Include pregnancy within three months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/25/48 at 4:00 P.M.
(b) Where did injury occur? 1203 Bolton Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: Self Inflicted

23. Signature John R. Oaks, M.D. (Medical Examiner)
Date signed 10/26/48

668025

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93 C

Registered No. 668025

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3114 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY LOVELACE ALLEN

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-4320

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 10, 1867

8. AGE: Years	Months	Days	If less than one day
81	6	15	hr. min.

9. Birthplace Spauling, Ga. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Rev. Thomas A. Allen
13. Birthplace Georgia

MOTHER
14. Maiden Name Emma W. Tarver
15. Birthplace Georgia

16 (a) Informant Mr. Howard L. Clark
(b) Address 207 Elm St., Elmira, N. Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltp., Md.

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1948, to 9-25 1948, and that I last saw h[illegible] alive on Oct. 27 1948.

Immediate cause of death	Duration
Arteriosclerotic heart disease	
Due to Arteriosclerosis, generalized Hypertension Cerebral Hemorrhage	
Due to disease	
Other Conditions Hypertrophic prostate with Retention (include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Date signed

668026 4 of 7

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 8316 ✓ Registered No. 668026

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address WOMANS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Princewick (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oakey Meadows
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Carrie Meadows
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr) 5-12-92

8. AGE: Years	Months	Days	If less than one day
56	5	13	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Deputy Sheriff
11. Industry or business

FATHER
12. Name Ben Meadows
13. Birthplace W. Va.

MOTHER
14. Maiden Name Virginia Cole
15. Birthplace W. Va.

16 (a) Informant WOMANS HOPKINS HOSPITAL
(b) Address BROADWAY & MONUMENT ST.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 10/26/48 (month) (day) (year)
(c) Cemetery or crematory PRINCE
Location PRINCE W. VIRGINIA

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St Paul St.

19 (a) OCT 26 1948 (Date rec'd by registrar) (b) Huntington W. Virginia Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1948, at 6 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1948, to 10-25 1948, and that I last saw him alive on 10-25 1948

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to Atherosclerosis	
Due to	
Other Conditions	

(Include pregnancy within three months of death)

Date of operation 24 Oct 48

Major findings of operation: Cerebral edema

of autopsy: Cerebral thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Jr. M.D.
Address Date signed 10/26

668027 Herman

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 548

Registered No. 668027

THERE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6707 Youngstown Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6707 Youngstown Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR J. MISKIMON

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elizabeth Dragler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/ 27/ 10

8. AGE: Years	Months	Days	If less than one day
38	7	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Arthur E. Miskimon
13. Birthplace Balto.

MOTHER
14. Maiden Name Ida May Thomas
15. Birthplace Balto.

16 (a) Informant Elizabeth Miskimon, (wife)
(b) Address 6706 Youngstown Ave.

17 (a) Burial (b) Date thereof 10/ 27/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Ext.
18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe Street
OCT 26 1948
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23/48 19 at 11 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 48 to 10/23/48
and that I last saw h alive on Oct 22/48

Immediate cause of death Metastases
Right Frontal Lobe — Duration 2 mos.
Due to
Due to
Other Conditions Suppuration
Mouth Gums
(Include pregnancy within 3 months of death) 6 days.
Date of operation
Major findings of operation: Neoplasm
Gross Examination
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Herrman M.D.
Address 1710 E 33 St Date signed 10/25/48

VS 150

X 18

G68028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

G68028 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ Hosp.
(c) Hospital or institution: Lombard Univ Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4512 Hampden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Ayres.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Flora Ayres

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 2 1890

8. AGE: Years 58 | Months 3 | Days 22 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name William Ayres

13. Birthplace Md.

MOTHER 14. Maiden Name Georgia Hersch

15. Birthplace md

16 (a) Informant Flora Ayres.

(b) Address 4512 Hampden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30/48 (month) (day) (year)

(c) Cemetery or crematory Wesley Chapel

Location Park Hall, Maryland

18 (a) Funeral director Morris V. Williams

(b) Address Chaptico Maryland

OCT 26 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1948, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1948 to Oct 25 1948.
and that I last saw h[illegible] alive on Oct 25 1948.

Immediate cause of death — Duration

cardiac failure

Due to Arteriosclerotic Coronary

Due to artery disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Shean M. D.

Address Univ Hosp. Date signed Oct 25, 48

-BC. 48-2264 BALTIMORE CITY HEALTH DEPARTMENT ✓ G68029
G68029 CERTIFICATE OF DEATH 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 16-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME BABY PORTER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8, 1948

8. AGE: Years | Months | Days | If less than one day: hr. 38 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Agnes Porter
15. Birthplace 1110 W. Lafayette Ave.

16 (a) Informant Agnes Porter
(b) Address 1110". Lafayette Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location
UNIVERSITY MEDICAL SCHOOL AUG 16 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 OCT 26 1948 (Registered by Registrar) (b) Huntington Williams, M.D.

VS 15+

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1948, at 7.38 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Prematurity, atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner
Date signed August 9, 1948

X

668030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

668030 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 0 1
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 Calvin Ave. #18 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME CHARLES HENRY DAVIS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: ?

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Nina Whaland
6 (c) If alive, give age: 64 years
7. Birth date of deceased (mo., day, yr.): 4/24/81
8. AGE: Years 67 | Months 6 | Days 2 | If less than one day: ..... hr. ..... min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business:

FATHER
12. Name: Charles E. Davis
13. Birthplace: Rock Hall, Md.

MOTHER
14. Maiden Name: Angeline Calvert
15. Birthplace: Queen Anne, Maryland

16 (a) Informant: Mrs. Louise Pack (daughter)
(b) Address: 416 Calvin Ave. #18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 24-48 (month) (day) (year)
(c) Cemetery or crematory: Wesley Chapel
Location: Rock Hall, Md.

18 (a) Funeral director: Geo. W. Lane
(b) Address: Rock Hall, Md.

19 Oct 27 1948 (Date rec'd by registrar) (Filing Number) Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1948, at 5 55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 1948 to 10/26 1948.
and that I last saw h[illegible] alive on 10/26 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	1 hr.
Due to Hemorrhage	2 days
Due to Bleeding Peptic Ulcer	16 years
Other Conditions (Include pregnancy within 3 months of death)	(Estimated)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature: W. Sasscer M.D.
Address: Md. Gen'l. Hosp. Date signed: 10/27/48

VS 190

G68031 n3 ✓ 13 c

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68031

LCH-83076

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1798 Eutaw Place (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Dietrich
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Arthur C.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 10/1 (~~1870~~) 1870
8. AGE: Years (75) 78 | Months 0 | Days 23 | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER / FATHER
12. Name Jacobs
13. Birthplace Maryland
14. Maiden Name ?
15. Birthplace Maryland

16 (a) Informant Balto. City Hosp. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

10 OCT 27 1948 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25/48 19 , at 4:25 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 8/6/43 19 , to 10/25/48 19 , and that I last saw h er alive on 10/25/48 19 .

Immediate cause of death Bronchopneumonia RLL LLL — Duration 3 wks 6

Due to

Due to Hypertensive arteriosclerotic

Other Conditions Heart disease Hypertrophic arthritis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David H. Maurer
Address Balto City Hosp Date signed 10-25-48 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G680~~32~~ APPROVED

BALTIMORE CITY HEALTH DEPARTMENT

Medical Examiner Case CERTIFICATE OF DEATH 186a

Registered No. G68032

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 180 N. Broadway
(c) Hospital or institution: Church Home and Hospital 9-08
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 E. 23rd St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Young

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 24, 1878

8. AGE: Years 70 | Months 5 | Days / | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Anton Young
13. Birthplace Germany

MOTHER
14. Maiden Name Ida Hillinginist
15. Birthplace Germany

16 (a) Informant Cleore Hoober
(b) Address Church Home Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1117 St. Paul St.

19 OCT 27 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1948 at 7:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1948 to Oct 25 1948 and that I last saw h[illegible] alive on Oct 25 1948.

Immediate cause of death: Epidural - Hemorrhage and Laceration into left cerebral Due to Hemisphere — Duration 12 hrs

Due to Fracture of skull in left temporal area — 12 hrs

Other Conditions Fractures of both radii and of left little finger

(Include pregnancy within 3 months of death)

Date of operation

Major findings of [illegible] CERTIFICATION APPROVED BY [illegible] Dr. John R. Davis M.D. Medical Examiner

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9-08
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Oct 25, 1948 at 6 A M
(c) Where did injury occur? 722 E. 23rd St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury Accidental fall down stairs

23. Signature Vernon T. Norwood M. D.
Address Church Home & Hospital Date signed 10-26-48

VS 153

G680333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1932

G680333
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Howard
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISA MIX

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1854

8. AGE: Years	Months	Days	If less than one day: hr.	min.
78	2	9		

9. Birthplace W Va (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER 12. Name Henry Schultz
13. Birthplace Germany

MOTHER 14. Maiden Name Anna K. Roper
15. Birthplace England

16 (a) Informant Mr Catherine Bayley
(b) Address 1510 Porter st Phila

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-32 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Baltimore Md

18 (a) Funeral director Wallace Cook Inc
(b) Address 1217 St Paul St

19 (a) OCT 27 1932 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1932, at 6.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1932, to 10-25 1932, and that I last saw h alive on 10-25 1932

Immediate cause of death	Duration
Cerebral Embolism	
Due to Arteriosclerosis	
Due to Hypertensive Arteriosclerotic C V Disease	
Other Conditions Generalized Arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Nicholson M D
Address University Hospital Date signed 10-25-32

VS 150

G68034

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

49a

Registered No. G68034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 541 West West St
(c) Hospital or institution: 7-1-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 541 W. West St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Luckett Pare

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Married

6 (b) Name of husband or wife Cliver Pare
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1893

8. AGE: Years	Months	Days	If less than one day
54	11	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Luckett
13. Birthplace Maryland

MOTHER
14. Maiden Name Druselle Farner
15. Birthplace Maryland

16 (a) Informant Cliver Pare
(b) Address 541 W. West Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27th 1948 (month) (day) (year)
(c) Cemetery or crematory Boyd Md
Location Boyd Md

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley e

19 (a) Date received by (Registrar) Oct 27 1948 (b) Filed

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1948. 5:30 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 1948 to Oct 25 1948.
and that I last saw her alive on Oct. 16 1948

Immediate cause of death	Duration
Respiratory failure	
Due to Carcinoma Ovary.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Aborafag M.D.
Address 601 N. Monroe St Date signed 10/29/48 M.D.

VS 150

68035

BALTIMORE CITY HEALTH DEPARTMENT 43 ✓ Registered No. 668035

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 21.01
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) D

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3521 Aisquith Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian C. Bahnmann Behrmann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1918

8. AGE: Years 30 | Months 2 mo | Days 26 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business

FATHER 12. Name John J. Eigner

13. Birthplace Balto. City Md

MOTHER 14. Maiden Name Katherine A. Killian

15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. J. J. Eigner

(b) Address 3521 Aisquith Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29, 1948 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Ave

18 (a) Funeral director Donaghue Funeral Home

(b) Address 7401 Belair Rd

19 (a) Oct. 27 1948 (Date received by Registrar) (b) Lemuel Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1948 at 11 20 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/21 1948 to 10/26 1948.
and that I last saw her alive on 10/26 1948

Immediate cause of death: Regurgitation Failure — Duration

Due to

Due to Tonsilosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: negat neg - except for flattened Tonsils and Crypts

of autopsy: Brain Degenerated

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles J. Blazek M.D.

Address Date signed 10/26/48

VS 180

Blazek

668036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. 668036

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1818 Bank St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No 1818 Bank St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Beckmann

3 (b) If veteran, name war

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 5th 1870

8. AGE: Years	Months	Days	If less than one day
78	5	20	hr min.

9. Birthplace New Orleans La.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Rosa George
15. Birthplace New Orleans La

16 (a) Informant Joseph Beckmann
(b) Address 1818 Bank St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30th 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo B. Brook
(b) Address 1701-03 N. Patterson Park ave

19 (a) OCT 27 1948 (Date rec'd by registrar) (b) Huntington Williams, Jr

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25th 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from [illegible] 19[illegible] to [illegible] 19[illegible], and that I last saw h[illegible] alive on [illegible] 19[illegible].

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M D

Address 1501 East [illegible] Date signed 10-16-48

VS 150

668037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19-07
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PERCY ADAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1923

8. AGE: Years	Months	Days	If less than one day
24 25	11	25	hr. min.

9. Birthplace Raleigh, N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Henry Knott

FATHER
12. Name George Adams
13. Birthplace Raleigh, N. C.

MOTHER
14. Maiden Name Lizzie Horton
15. Birthplace Raleigh, N.C.

16 (a) Informant Percy Horton
(b) Address 1909 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27, 1948 (month) (day) (year)
(c) Cemetery or crematory Raleigh, Location North Carolina

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) OCT 27 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 1ST

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1948, at 10.00 a.m.

21. I certify that I took charge of the remains described above, held an partial autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify)
(d) Means of injury

23. Signature Earl L. Royster M.D. (Medical Examiner)
Date signed October 25, 1948

G68038

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95B

Registered No. G68038

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTIMORE CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 W. SARATOGA ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM HOLLAND.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ??? ?

8. AGE: Years 41 ? | Months | Days | If less than one day ... hr. ... min.

9. Birthplace MARYLAND. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name WILLIAM (D)
13. Birthplace MD.

MOTHER
14. Maiden Name JOSEPHINE SCOTT.
15. Birthplace MD.

16 (a) Informant B.C.H. RECORDS.
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27-1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus memorial Pk
Location Arbutus Md

18 (a) Funeral director Robert E. Kilcoyne
(b) Address 1515 McElderry St

19 (a) OCT 27 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23-48 19 at 820 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22-48 19 to 10-23 19 43 and that I last saw HIM alive on 10-23-48 19

Immediate cause of death Pulmonary edema

Duration 1 day

Due to ~~Hypertensive Arteriosclerotic~~ Rheumatic Heart Disease

Duration 3-4 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Stuttman M.D.
Address Balto. City. Hosp. Date signed 10-25-48

VS 130

X

CORRECTIONS AND ERASURES, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68039

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6504 Brighton Ave.,
(c) Hospital or institution: [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6504 Brighton Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Manning,

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex female | **5. Color or race** white | **6 (a) Single, married, widowed, or divorced.** married

6 (b) Name of husband or wife James P. Manning.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 12, 1884

8. AGE: Years 64 | Months 7 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Ireland.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business at home

FATHER
12. Name Daniel Carroll,
13. Birthplace Ireland.

MOTHER
14. Maiden Name Catherine Boyle,
15. Birthplace Ireland.

16 (a) Informant Mr. James P. Manning.
(b) Address 6504 Brighton Ave.,

17 (a) burial (Burial, cremation, or removal) **(b) Date thereof** 10/28/48 (month) (day) (year)
(c) Cemetery or crematory St. Charles Cem.
Location Pikesville, Md.

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 OCT 27 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1948 at P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to 10/25 1948, and that I last saw her alive on 10/25 1948.

	Duration
Immediate cause of death: Cerebral Hemorrhage	4 days
Due to: Hypertensive Cardiovascular disease	+ yrs
Due to: Pernicious anemia	+ yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 4843 Park Heights. **Date signed** 10-26-48

G68040

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68040

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2930 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2930 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES R. SCOTT

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 380-05-6085

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Laura J. Scott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): March 31, 1899

8. AGE: Years 49 | Months 6 | Days 24 | If less than one day: hr. min.

9. Birthplace: Bradford, Mass.
(Town, county, and state)
10. Usual Occupation: Resident Comptroller
11. Industry or business: Fisher Body Div. of Balto.

FATHER
12. Name: Charles Scott
13. Birthplace: Canada

MOTHER
14. Maiden Name: Bernice Nash
15 Birthplace: Brasher Falls, N. Y.

16 (a) Informant: Mrs. Laura J. Scott
(b) Address: 2930 N. Calvert St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)
(c) Cemetery or crematory
Location: Amesbury, Mass.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

1948 OCT 27 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 25th 1948 at 10.15P M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to Oct 25 1948, and that I last saw h[illegible] alive on Oct. 25 1948.

Immediate cause of death: Coronary Thrombosis — Duration: Immediate
Due to
Due to
Other Conditions: Duodenal ulcer — Duration: many years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Nathaniel M Beck M.D.
Address: 100 E. 23rd St Date signed: Oct 25-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G68041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68041

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2804 Loudon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2804 Loudon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CONDON ELLSWORTH VARINA

3 (b) If veteran, name war: -

3 (c) Social Security Account No. -

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Martha E. Varina

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 24, 1861

8. AGE: Years 87 | Months 8 | Days 1 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Hardware Dealer (retired)

11. Industry or business:

FATHER
12. Name: Edward Varina
13. Birthplace: Mass.

MOTHER
14. Maiden Name: Mary Disney
15. Birthplace: Maryland

16 (a) Informant: Mr. James Varina
(b) Address: 2804 Loudon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 27 1948 (Date rec'd by registrar) (b) Funeral Director, Williams, M.D.

VS 15)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1948 to Oct. 25 1948, and that I last saw h[illegible] alive on Oct. 23 1948.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Senility	
Due to	
Other Conditions Chr. Nephritis	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D. M. D.
Address 820 Medical Arts Bldg Date signed 10/26/48

744

668042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

84a

Registered No. 668042

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Charles

(c) City or town Port Tobacco (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Compton (Margaret) (235231)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 1, 1948

8. AGE: Years	Months	Days	If less than one day
		16	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Colvin Compton

13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret Selby

15. Birthplace Maryland

16 (a) Informant Hospital Record

(b) Address 601 North Broadway

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) OCT 27 1948 (b) (Date rec'd by registrar)

VOID

SEE 7723

6

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1948, at 3:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from October 1 1948 to October 17 1948, and that I last saw her alive on October 17 1948.

Immediate cause of death Atelectasis

Due to

Due to

Other Conditions Mongolism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul D Burns M. D.

Address Johns Hopkins Date signed 10/28/48

VS 150

161a

668043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No. 668043

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 N Paca St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 N Paca St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Henry Wright

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/6/81

8. AGE: Years 67 | Months 8 | Days 19 | If less than one day: hr min.

9. Birthplace East New Market Md (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name William Thompson
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Thompson
15. Birthplace Maryland

16 (a) Informant Myrtle L Smyrl
(b) Address 603 N Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Thompson Town church
Location East New Market Md

18 (a) Funeral director Wm A Jackson
(b) Address 966 Penna Ave

19 OCT 27 1948 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25 1948 at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1948 to 10/25 1948.
and that I last saw her alive on 10/25 1948

Immediate cause of death (a) Arteriosclerotic Heart Disease — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Donner M.D.
Address 253 Georgia Ave Date signed 10/28/48

VS 150

TYPE OR PRINT IN INDELIBLE PENCIL OR WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68044 BALTIMORE CITY HEALTH DEPARTMENT 68044
CERTIFICATE OF DEATH 93d Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 224 S. Patterson Park ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 224 S. Patterson Park ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Branislawa Rutkowski
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Julian Rutkowski
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House work
11. Industry or business

FATHER
12. Name Maciej Palanowski
13. Birthplace Poland

MOTHER
14. Maiden Name Antonina Koscielska
15. Birthplace Poland

16 (a) Informant Mrs. Julian Rutkowski
(b) Address 224 S. Patterson Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION 9 10

20. DATE OF DEATH Oct 25 1948 at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1948 to Oct. 26 1948. and that I last saw her alive on Oct. 4, 1948.

Immediate cause of death	Duration
Arteria sclerotic cardio-vascular disease	years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sigmund R. Nowak M.D.
Address 408 S. Patt. Pk. Ave Date signed 10/26/48

VS 8

...WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68045

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St
(c) Hospital or institution: Good Samaritan Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 306 N Parrish St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Needham (Needom)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Charles Needham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
67				

9. Birthplace Warrington Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Arundle Co Md

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna

19 (a) (b)

20 (Signature and title of person acting) Register Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22/48 19 . at 10 50 M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/19/48 to 10/22/48, and that I last saw h alive on 10/21/48

Immediate cause of death	Duration
Chronic Myocarditis	years
Due to Cerebral Hemorrhage	
Due to Uremia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter T Loxton

Address 502 Edmondson Date signed 10 28 48

M. D.

G68046

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68046 Registered No. 131

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 926 PENNA AVE
(c) Hospital or institution: 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 PENNSYLVANIA AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** EDWARD EARLY

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-5447

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	COL	MARRIED

6 (b) Name of husband or wife ELIZABETH
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 4-7-1911

8. AGE: Years	Months	Days	If less than one day
30	6	21	hr. min.

9. Birthplace WILSON N. C. (Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business —

FATHER — 12. Name	EDGAR L. EARLY
FATHER — 13. Birthplace	N. C.
MOTHER — 14. Maiden Name	HATTIE VALENTINE
MOTHER — 15. Birthplace	N. C.

16 (a) Informant ELIZABETH EARLY
(b) Address 926 PENNA AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/48 (month) (day) (year)
(c) Cemetery or crematory Conway MD
Location Potterway MD

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna Ave

10-27-1948 (Date rec'd by registrar) (c) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT-27 1948 at 9:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1947 to Oct 27 1948 and that I last saw him alive on Oct. 20 1948

Immediate cause of death: Pulmonary collapse — Duration: 17 mos

Due to: Pulmonary Tuberculosis

Due to:

Other Conditions: Cirrhosis. Edmundson
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. M. S. K. Reesby M. D.
Address 756 Dolphin St Date signed 9/27/48

VS 150

X

G68047

ES- 122823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a Registered No. G68047

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 311 N. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Jones

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 58? Months Days If less than one day hr. min.

9. Birthplace Unable to Obtain Information.
(Town, county, state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant RECORDS- BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 26 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 2 8 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23 1948 at 1:45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-9- 1948 to 9-23 1948 and that I last saw her alive on 9-23 1948

Immediate cause of death Uremia — Duration 10 days

Due to Chronic pyelonephritis or arteriolar nephrosclerosis — Duration 19 years

Due to

Other Conditions Hypertensive heart disease Old hemiplegia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

25. Signature David H. Marrin M.D.
Address Balto City Hosp Date signed 10-28-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68048

AB–109128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30e

Registered No. G68048

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1519 Riggs Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15- 1892

8. AGE: Years	Months	Days	If less than one day
56	4	8	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name George Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Lisa ?
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School OCT 26 1948

18 (a) Funeral director Commissioner of Health

(b) Address 1948

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1948 at 4 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-13---- 1947 to 10-7- 1948, and that I last saw him alive on 10-7- 1948

Immediate cause of death Cardiac failure

Duration

Due to Syphilitic heart disease aortic insufficiency

Due to

Other Conditions General paresis
Old amputation left leg.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature David Marine

Address Balto. City Hosp. Date signed 10-11-48

OCT 28 1948

VS 150

G68049

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13L Registered No. G68049

LCH-123060

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos. or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 Lexington Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME LEE RICKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6/15/1886

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Allen F. Ricks
13. Birthplace N.C.

MOTHER
14. Maiden Name Maria ?
15. Birthplace N.C.

16 (a) Informant Balto. City Hosp. Records
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 26 1948

18 (a) Funeral director Commissioner of Health
(b) Address OCT 26 1948

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17/48 (Month) (Day) (Year) at 4:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/17/48 to 10/17/48 and that I last saw him alive on 10/17/48

Immediate cause of death Bilat. far advanced Pulmonary tuberculosis — Duration 6 mos

Due to —

Due to

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank W. Shipley M.D.
Address Balto. City Hosp. Date signed 10/21/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

68050
JL - 124015

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

137 Registered No. G68050

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 S. Green St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Clarence Matthews

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Emma Matthews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 4, 1887

8. AGE: Years	Months	Days	If less than one day
61	3	21	hr min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 astern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Isaac L Brown Son
(b) Address 1058 W Monument St

19 (a) Huntington Williams, M.D. (b) Registrar
Date rec'd by local registrar OCT 27 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1948, at 11.40 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 24, 1948, to Oct. 25 1948 and that I last saw h im alive on Oct. 25 1948.

Immediate cause of death
Uremia — Duration 1 wk
Due to Bilateral pyonephrosis hydronephrosis and hydroureters — over 2 yr.
Due to Benign prostatic hypertrophy — 3-4 yr.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature L. Stutzman M. D.
Address Balto. City Hosp. Date signed 10-26-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The correct name of informant should be carefully supplied.

668051

Leh 16062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

53

668051
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Frederick St. & Fayette St. (If rural, give R.F.D. or location)
Balto City Hosp
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Oeste

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1864

8. AGE: Years	Months	Days	If less than one day
84	0	19	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Shoemaker

11. Industry or business

FATHER
12. Name John Oeste
13. Birthplace ? Germany

MOTHER
14. Maiden Name Eva Stock
15. Birthplace ? Germany

16 (a) Informant Balto. City Hospl records
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 26 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 27 1948 (Date rec'd by registrar) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1/48 19 at 19:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30/14 19 to 10/1/48 19 ; and that I last saw him alive on 10/1/48 ?

Immediate cause of death Bronchopneumonia — Duration 20 days

Due to

Due to

Other Conditions Surgical absence of rt eye. Basal cell carcinoma (Include pregnancy within 3 months of death)

Date of operation 8/15/48 of lid & lid

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Marine M.D.
Address Balto City Hospls Date signed 10-4-48

VS 150

107

Cc 48-2385P
G68052

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160a G68052 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2235 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Martin ~~Ayers~~ Ayers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-25-48

8. AGE: Years	Months	Days	If less than one day
0	0	3	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation infant
11. Industry or business

FATHER 12. Name Ira L. Ayers
13. Birthplace Tenn.

MOTHER 14. Maiden Name Dessie Hillen
15. Birthplace Tenn

16 (a) Informant Father (Ira L. Ayers)
(b) Address same

17 (a) Burial (b) Date thereof 10 28 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Baltimore Co. Md.

18 (a) Funeral director H. W. Meyers and Son
(b) Address 802 N. Calvert St.

OCT 27 1948 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27- 1948 at 9:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25- 1948 to 10-27-1948.
and that I last saw h~~e~~r alive on 10-27-1948.

Immediate cause of death	Duration
Resp. failure	
Due to Intracranial Hemorrhage	3 hrs
Due to Erythroblastosis fetalis	3 days (Life)
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allyn F. Judd M. D.
Address Mercy Hospital Date signed 10-27-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68053

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68053

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3/4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore (Penna Ave del)
(c) City or town North Linthicum, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Charles Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Becker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/3/1881

8. AGE: Years	Months	Days	If less than one day
66	10	23	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Fisher
13. Birthplace Switzerland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany

16 (a) Informant Mr Wm J Becker
(b) Address 5 Charles Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director J. J. Gibbons & Sons
(b) Address 1818 Light St

19 (a) (Date rec'd by registrar) (b) Registrar

Nov 29 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1948, at 3:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1948 to 10/26 1948, and that I last saw her alive on 10/26 1948.

Immediate cause of death	Duration
Acute congestive myocardial failure	6 hours
Due to Acute coronary thrombosis	12 hours
Due to Hypertensive-Arteriosclerotic Cardiovascular-Renal Disease	? years
Other Conditions Pulmonary edema	6 hours

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy 10/26/48 Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred N. Dann M. D.
Address Maryland General Hosp. Date signed 10/26/48

668054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668054

Registered No. 92d

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or Institution:
St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Liberty Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Esther Grolman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Late Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 14, 1867

8. AGE: Years 80 | Months 11 | Days 13 | If less than one day hr. min

9. Birthplace Lativa
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Arron Deitch
13. Birthplace Lativa

MOTHER
14. Maiden Name Laura ?
15. Birthplace Lativa

16 (a) Informant Arther Raffel
(b) Address 2903 Mt Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct, 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Rd Cem
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1948 at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15, 1948 to Oct. 27, 1948 and that I last saw her alive on Oct. 27, 1948.

Immediate cause of death Hypostatic Pneumonia — Duration

Due to Coronary Thrombosis

Due to Arterio Sclerotic Heart Disease

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Ray C. Parsons Jr. M.D.
Address 1124 W. North Ave Date signed 10/27/48

VS 150

CORRECT NAME PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G68055

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1003 Sterrett St

(c) Hospital or institution: 7-1-01

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1003 Sterrett St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Augusta Zelinka

3 (b) If veteran, name war: No

3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23-1914

8. AGE: Years	Months	Days	If less than one day: hr.	min.
34	8	3		

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Technician

11. Industry or business Mercy Hosp.

FATHER

12. Name Joseph Zelinka

13. Birthplace Austria

MOTHER

14. Maiden Name Margaret Pisna

15. Birthplace Md.

16 (a) Informant Paul A Zelinka

(b) Address 2205 Reedy St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Holy Redeemer

Location Balto. Md

18 (a) Funeral director Wm. Cook Inc.

(b) Address 1217 St Paul St

19 OCT 28 1948 (Date rec'd by registrar) Clinton for Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1948, at 10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-25 1948 to 10-26 1948, and that I last saw h[illegible] alive on 10-26 1948.

Immediate cause of death

Congenital Heart Disease

c Ventricular Septal Defect

Due to c Complete Heart Block

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None done

Major findings of operation: None done

of autopsy:

Duration

Birth

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify)

(e) Means of injury

23. Signature Alan Gilman, M D

Address 1401 E. Pratt St Date signed 10-27-48

Alan Gilman

VS 150

G68056

J1 - 89252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

G68056
Registered No.

Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. No Home Address
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Flint

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No Record

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Div.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1901

8. AGE: Years	Months	Days	If less than one day
46	10	25	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name James Flint
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Gray
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1948, at 6.30 Am M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1944 to Oct. 26 1948.
and that I last saw him alive on Oct. 26 1948.

Immediate cause of death	Duration
Bronchopneumonia R.L.L.	
Due to LAENNEC'S CIRRHOSIS	
Due to Myelomyeloma	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
ABOVE
of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Warren E. Porter M.D.
Address Balto. City Hospitals Date signed 10/26/48

668057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

Registered No. 668057

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1332 N. Ellwood Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1332 N. ELLWOOD AVE (If rural give location)

(e) Citizen of foreign country? (Yes or No). If yes, name country

3 (a) **FULL NAME** CLEMENTINA FIORELLI

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife VERINO FIORELLI

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 1 1894

8. AGE: Years	Months	Days	If less than one day
53	10	26	hr. min.

9. Birthplace ITALY (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name DOMINCK CAPANNA

13. Birthplace ITALY

MOTHER 14. Maiden Name UNKNOWN

15. Birthplace ITALY

16 (a) Informant EDITH WEINBERGER

(b) Address 1332 N. ELLWOOD AVE

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 10/30/48 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Holy Redeemer

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 327 St. Paul St.

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27 1948 at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2 1946 to 7-19 1948 and that I last saw h ~~er~~ alive on 7-19-1948.

Immediate cause of death	Duration
arteriosclerotic heart disease	2
hypertension	
Due to Cerebral arteriosclerosis	2
Cardiac enlargement	
Due to arteriosclerosis	
Other Conditions Chronic gall-bladder disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. A. Michelson M. D.

Address 2230 Eutaw Pl. Date signed 10/29/48

VS 150

6680:58

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6680:58

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 15, Box 166 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nesitt Edwards

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife Bertha Edwards
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr) 8-16-89

8. AGE: Years	Months	Days	If less than one day
59	2	10	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Shipyard Carpenter
11. Industry or business

FATHER
12. Name Philip Edwards
13. Birthplace England

MOTHER
14. Maiden Name T. Betterton
15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/31/48 (month) (day) (year)
(c) Cemetery or crematory Orems Methodist
Location Middle River, Md.

18 (a) Funeral director Kavanaugh Funeral Service
(b) Address 7 E. Belair Road

19 (a) OCT 28 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1948, at 10:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1948, to 10-26 1948, and that I last saw him alive on 10-26 1948.

Immediate cause of death	Duration
Cerebral vascular Thrombosis in region of hypothalamus	
Due to Cerebral arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Thrombosis of basilar artery, middle cerebral artery

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. W. Jackson M. D.
Address The Johns Hopkins Hosp. Date signed 10/27/48

VS 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 68059

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5823 Belair Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5823 Belair Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LOUIS E. O'HARE, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-1238 A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married.

6 (b) Name of husband or wife Henrietta E. O'Hare

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 13th, 1879

8. AGE: Years	Months	Days	If less than one day
68	11	13	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Mill Worker
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Hugh O'Hare
13. Birthplace Ireland

MOTHER
14. Maiden Name Rose Fitzimmons
15. Birthplace Ireland

16 (a) Informant Mrs. Louis E. O'Hare, Sr.
(b) Address 5823 Belair Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) Oct 28 1948 (b) Registrar Huntington Williamson Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26th, 19 48, at 12 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1948 to Oct 26 1948, and that I last saw him alive on Oct 25 1948

Immediate cause of death
Cerebral Hemorrhage — Duration 2 wks.
Due to Arteriosclerosis — many yrs.
Due to
Other Conditions Pneumonia
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mark K. English M. D.
Address 5713 Belair Rd Date signed 10-27-48

Mark K. English

VS 153

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668060 123991

B.C. 48-28878

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

81 a 668060 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Balto. city hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence T. Larkins.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	col.	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 48

8. AGE: Years	Months	Days	If less than one day
5 wks.	1	5	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Ruth Larkins.
15. Birthplace Md.

16 (a) Informant Records, Balto. city Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 10-26-48 (month) (day) (year)
(c) Cemetery or crematory B. C. H. Crematory
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 OCT 28 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23-48 19 at 6 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23/ 19 48 to 10/23/ 19 48 and that I last saw her alive on 10/23/ 19 48

Immediate cause of death	Duration
(a) Meningitis Staphylococcal	2 hrs.
Due to (b) Staphylococcal Pneumonia	2 wks.
Due to (c)	
Other Conditions Prematurity.	5 weeks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: (

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Statistical information should be carefully prepared.

VS 150

X

668061

B 71123527 48-2094

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119 a Registered No. 668061

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Back River Neck Rd. -21
(If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME David M. Aldao

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26. 1948.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
—	—	29		

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Rex Aldao
13. Birthplace Italy

MOTHER
14. Maiden Name Florina Bowen
15. Birthplace W. Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 10-26-48 (month) (day) (year) 9 am
(c) Cemetery or crematory B. C. H. Crematory
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Tuntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1948 at 5.45 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5 1948 to Oct. 25 1948, and that I last saw h[illegible] alive on Oct. 25 1948

Immediate cause of death: Intussusception — Duration: 3 wks.

Due to: Diarrhea & vomiting — Duration: 3 wks.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Intussusception

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address Date signed

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use only black ink. Do not use abbreviations. Answer all questions fully and correctly. Be sure that all items are supplied. The

G68062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

461

Registered No. G68062

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1704 Belt Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 04
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Belt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIUS YANKE

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Wilhelminia Kintop
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/22/1875

8. AGE: Years	Months	Days	If less than one day
73	2	3	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Self

FATHER
12. Name William Yanke
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta ?
15. Birthplace Germany

16 (a) Informant Family
(b) Address Same

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10/28/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway, Brooklyn

18 (a) Funeral director James L. McCauley
(b) Address 130 East Fort Avenue

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1948, at 12 30 M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1 1948, to Oct 25 1948
and that I last saw h alive on Oct 24 1948.

Immediate cause of death Carcinoma Rectum. — Duration

Due to —

Due to —

Other Conditions Hypertension. Broncho-pneumonia (Terminal)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur C. Schenck M.D.
Address 133 S. Charles St Date signed 10/29/48

VS 190

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131

Registered No. G68063

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1401 Tenpin Alley
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 Tenpin Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence V. Lee

3 (b) If veteran, name war 1

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Sep

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 11 1897

8. AGE: Years 50 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Caulker

11. Industry or business

FATHER 12. Name George Lee
13. Birthplace Md

MOTHER 14. Maiden Name Anabelle Brown
15. Birthplace Md

16 (a) Informant Mrs Sadie Rawlins
(b) Address 1401 Tenpin Alley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 48 (month) (day) (year)
(c) Cemetery or crematory E. S. Balto National
Location Baltimore

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) OCT 28 1948 (Date rec'd by Registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26th 1948 at 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23 1948 to Oct 1948 and that I last saw him alive on 24th Oct 48

Immediate cause of death Advanced Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris A. Frus M. D.

Address 118 Bigelow Date signed

VS 150

X

G68064
AB-123837

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 136

G68064
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Clanton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-12-1917

8. AGE: Years	Months	Days	If less than one day
31	7	13	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Rev. Samuel Clanton 1D
13. Birthplace N.C.

MOTHER
14. Maiden Name Ella Thorne
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 10-28-48 (month) (day) (year)
(c) Cemetery or crematory Norlina
Location N.C.

18 (a) Funeral director Rayner & Sanders
(b) Address 14 E. B. Preston St. Huntington, W. Va.

19 (a) OCT 28 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25- 1948 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18- 1948 to 10-25- 1948. and that I last saw him alive on 10-25- 1948

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary tuberculosis	Several years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pulm tbc

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L Gayle Burton M D
Address Baltimore City Hospitals Date signed 10/26/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

68065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

Registered 68065

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 12-05
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 24hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Latrobe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LUNER MOSLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 22, 1888

8. AGE: Years 60 | Months 7 | Days 4 | If less than one day hr. min

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Calvin Mays
13. Birthplace S. C.

MOTHER
14. Maiden Name Estella Montgue
15. Birthplace S. C.

16 (a) Informant Julia Cobert
(b) Address 123 W. 22cnd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 30-48 (month) (day) (year)
(c) Cemetery or crematory U.S. Balto National
Location Baltimore

18 (a) Funeral director Rayner Sanders
(b) Address 1415 E. Preston St

19 (a) OCT 28 1948 (Registered by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26, 1948 19 , at 9:08 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Shock due to multiple contusions and fractures of the facial bones.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 26/48 at 3:30 A.M.
(b) Where did injury occur? Baltimore-Balt. Md.
Did injury occur at home, on farm, industrial place, in public place? Home While at work? Asleep
(d) Means of injury Blunt force

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10/27/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓

Registered No. 68066

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 520 N LOUDON AVE
(c) Hospital or institution:
2007
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 N. LOUDON AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Malcolm A. Campbell, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of ~~husband~~ or wife late NELLIE V

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 23, 1894

8. AGE: Years 54 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation MANAGER

11. Industry or business NASH KELVINATOR

FATHER
12. Name MAC DOUGAL CAMPBELL
13. Birthplace SCOTLAND

MOTHER
14. Maiden Name ?
15. Birthplace U.S.A.

16 (a) Informant MALCOLM CAMPBELL JR
(b) Address 520 N. LOUDON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 30 '48 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location TAYLOR AVE

18 (a) Funeral director Harry H Weyler
(b) Address 4101 Edmondson Ave, Baltimore, Md

19 (a) OCT 28 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Oct. 1948, at 12 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammer Jr M.D.
Medical Examiner.
Date signed 27 Oct-48

VS 151

Enter age if especially important. Physicians: please write the causes of death clearly and legibly.

668067

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 668067

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 69 N. Monastery Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Paul Medford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary C. Parker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/3/1893

8. AGE: Years	Months	Days	If less than one day
55	0	3	hr. min.

9. Birthplace Md (Town, county and state)
10. Usual Occupation Bookkeeper
11. Industry or business

FATHER
12. Name Jesse L. Medford
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Bousel
15. Birthplace Md

16 (a) Informant Mrs Mary Medford
(b) Address 69 N. Monastery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 '48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Harry A Wilkes
(b) Address 4300 Edmondson Ave

19 (a) OCT (Date rec'd by registrar) Registrar for Williams Mc

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1948, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1948 to 10/26 1948, and that I last saw him alive on 10/26 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary occlusion	
Due to Coronary occlusion	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carlton J. Blanck M. D.
Address Maryland Gen. Hosp. Date signed 10/26/48

VS 190

668068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 41c

668068 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkins

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2529 Christian St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William L. Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	WIDOWED

6 (b) Name of husband or wife Late KATHERINE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) AUG. 18, 1885

8. AGE: Years	Months	Days	If less than one day
63 69	2	9	hr. min.

9. Birthplace Md. (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER

12. Name Thomas

13. Birthplace Md

MOTHER

14. Maiden Name Annie

15. Birthplace Md.

16 (a) Informant Mrs Lucy A McKay

(b) Address 2413 James St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct 29 '48 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location 3801 FREDERICK AVE

18 (a) Funeral director Harry A Wiltze

(b) Address 4101 Edmondson Ave

19 (a) OCT 28 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 19 48 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5 1948 to 10/26 1948 and that I last saw him alive on 10/26 1948.

Immediate cause of death Cardiac Failure

Duration: Admit 8-5-48 Died 10/26/48 (83 days)

Due to Primary Bronchiogenic Ca of Left Lung & Abcess

Due to Formation

Other Conditions

(Include pregnancy within 3 months of death)

CERTIFICATION APPROVED BY

Earl Rose

CHIEF OR ASST. MEDICAL EXAMINER

Date of operation 10/19/48

Major findings of operation: Ca of left lung & extension to Abcess Formation

of autopsy: Ca of Bronchus Originating

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John J. Tansey M. D.

Address St Agnes Hosp Date signed 10/27/48

VS 153

To be approved by Medical Examiner

68069 Dr. Gordy

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

41a ✓

Registered No. 68069

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5112 Richard Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5112 Richard Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christian Frederick Moebus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 5, 1885

8. AGE: Years	Months	Days	If less than one day
63	7	22	hr. min.

9. Birthplace Aberdeen, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Moebus
13. Birthplace Germany

MOTHER
14. Maiden Name Mary F. Schmidt
15. Birthplace Germany

16 (a) Informant Mrs. Margaret C. Moebus
(b) Address 5112 Richard Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Oct 28 1948 (Date received by Registrar) (b) Huntington Williamsport, Md.

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1948, at 1-30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1948 to Oct 27 1948, and that I last saw h in alive on Oct 26 1948

Immediate cause of death Carcinomatosis of Lung — Duration 1 year

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury None

23. Signature T. F. Gordy M.D.
Address 7 Va Harford Rd Date signed 10/28/48

+

G68070

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. G68070

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital ~~or Institution~~ St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Edison Highway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mother Mary Generosa, O.S.F.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1876

8. AGE: Years	Months	Days	If less than one day
72	1	3	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name McCafferty
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Sr. M. Constantine
(b) Address 2810 Edison Hgway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 48 (month) (day) (year)
(c) Cemetery or crematory Our Lady of Angels
Location Glen Riddle, Pa.

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1948 at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1948 to Oct 26 1948 and that I last saw her alive on Oct 26 1948

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Generalized Arteriosclerosis	
Due to	
Other Condition Hypostatic pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ray E. Personeni Jr. M.D. M.D.
Address St. Joseph's Hosp. Date signed 10/26/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G68071

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner Ave & Dukeland St.

(c) Hospital or institution West. Baltimore General 16 06

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2858 W. Lanvale St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Susan Florence Norlamus

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John Norlamus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1884

8. AGE: Years	Months	Days	If less than one day
63	11	16	hr. min.

9. Birthplace Reisterstown Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Patrick McCartin

FATHER 13. Birthplace Ireland

MOTHER 14. Maiden Name Not Known

MOTHER 15. Birthplace Not Known

16 (a) Informant Mrs. Katherine DiPaula

(b) Address 2858 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-1948 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore, Md

18 (a) Funeral director H. Howard Strong

(b) Address 3207 W. North Ave.

(b) Washington Funeral Home

Date received by registrar 10-28-1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27/48 19 , at 8:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23/48 19 to 10/27 19 48.

and that I last saw h alive on 10/27 19 48.

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm D. Dana M. D.

Address 10-27-48 Date signed 10-27-48

Wm Botto Ben Dog

668072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1/2 Registered No. 668072

668072

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1125 Sharp Street
(c) Hospital or institution: 7301
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Sharp Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lorraine Bass

3 (b) If veteran, name war ----

3 (c) Social Security Account No. -----

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/16/1928

8. AGE: Years 19 | Months 10 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore City (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Wiley Bass
13. Birthplace N.C.

MOTHER
14. Maiden Name Carrie Lyons
15. Birthplace Baltimore, City

16 (a) Informant Carrie Bass
(b) Address 1125 Sharp Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem
Location Balto Co.

18 (a) Funeral director Sarah I. Brown & Son
(b) Address 108 W. Montgomery Street

19 (a) OCT 28 1948 (b) Registrar Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1948, at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1948, to Oct. 25, 1948 and that I last saw her alive on Oct. 20, 1948.

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris M. D.

Address 824 W. Franklin St Date signed 10-26-48

VS 150

Every item of information should be carefully supplied. TM
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 2

Registered No. 668073

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 35 N. Potomac St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 01
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 35 N. Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma M. White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph T. White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 24, 1893

8. AGE: Years 55 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Alexanda Paget
13. Birthplace Germany

MOTHER 14. Maiden Name Marie Rinkhoff
15. Birthplace Germany

16 (a) Informant Joseph T. White
(b) Address 35 N. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Rd.

18 (a) Funeral director John A. Mayer
(b) Address 3006 E. Balt. St.

19 (a) OCT 28 1948 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 48, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 48 to Oct 26 48.
and that I last saw h alive on 6 26 48

Immediate cause of death: Carcinoma

Due to Skull Involvement

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: ---

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Kent Gurley M. D.
Address 2906 E Balt Date signed 10 28 48

VS 150

68074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68074

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave.
(c) Hospital or institution: Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 N. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY SUTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife: George Suter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1877

8. AGE: Years	Months	Days	If less than one day
71	8	4	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Dallas E. Breshmiller
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name M. Martha Tatham
15. Birthplace Balto., Md.

16 (a) Informant Mrs. M. C. Collector, daughter
(b) Address 1821 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26, 1948 at 5:30 A M

21. I certify that death occurred on the date above stated, and that I attended deceased from Aug 1 - 48 to Oct 26 48, and that I last saw h[illegible] alive on Oct 25 48

Immediate cause of death: Cerebral Hemorrhage — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry C Houck
Address 1[illegible] Date signed Oct 28/48

VS 153

G68075

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

932 Registered No. G68075

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 S. Chapel Gate Lane
(c) Hospital or institution: Ventnor Lodge
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3443 Park Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CARLO LEONE

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
none	none	male	white	married

6 (b) Name of husband or wife Virginia Leone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)	8. AGE: Years	Months	Days	If less than one day hr.	min.
June 22, 1888	60	4	5		

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Self

FATHER
12. Name Lewis Leone
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Virginia Leone
(b) Address 3443 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1948 at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1948 to October 27 1948, and that I last saw h im alive on Oct 25 1948

Immediate cause of death Myocarditis — Duration Months

Due to Arterio-sclerosis generalized — Duration years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Henry M. Herman M D
Address 702 E. Preston St. Date signed 10/29/48

VS 150

G68076

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

Registered No. G68076

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 W Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REBECCA BRISCOE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Richard Briscoe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1873

8. AGE: Years 75 | Months 4 | Days — | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant: Isabelle Friesen
(b) Address: 1421 " Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: October 28, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) OCT 28 1948 (Date rec'd by registrar) (b) Funeral for Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1948, at 8.10 PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.
Date signed 10/25/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68077

FL - 123954

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

932

G68077
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Galloway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Alberta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 29. 1871

8. AGE: Years	Months	Days	If less than one day
77	6	28	hr min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Galloway
13. Birthplace Md.

MOTHER
14. Maiden Name Melinda Johnson
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Oct. 30, 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Am.
Location

18 (a) Funeral director Mrs. Ketie R. Williams
(b) Address 322 N. Schroeder St

19 (a) OCT 28 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1948, at 2.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1948, to Oct. 27 1948, and that I last saw him alive on Oct. 27 1948.

Immediate cause of death	Duration
Pulmonary edema	1 day
Due to Cardiac failure	2 3 wk.
Due to Arteriosclerotic Heart Disease	3-4 yr.
Other Conditions Bronchopneumonia	1 wk.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Stutzman M. D.
Address Balto. City Hosp. Date signed 10-27-48

VS 153

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use only black ink. Do not write in margins. Do not use abbreviations. Be careful not to overwrite.

G68078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 C

G68078 Registered No.

Please write the causes of death clearly and legibly. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 2476 Shirley Ave
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Avenue oad
(c) Hospital or institution: Mt Carmel Home 15 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3730 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda Kaffeman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1878

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Usher Presman
13. Birthplace Poland

MOTHER
14. Maiden Name Unkown
15. Birthplace Poland

16 (a) Informant Gershon Kaffeman
(b) Address 3730 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date received) (b) (Registrar)
OCT 28 1948 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1948, at 9:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Oct 28 1948, and that I last saw h-- alive on Oct 27 1948.

Immediate cause of death Central Embolism — Duration 1 mth.

Due to Arteriosclerosis + Cardiac Hypertrophy + ?

Due to Failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rachel H. Kalman MD M.D.
Address 3700 Park Heights Ave Date signed Oct 28 1948

Medical Examiners Released to Hospital

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13½ Registered No. 68079

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-0-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Mc Elderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7-17-1913

8. AGE: Years	Months	Days	If less than one day
35	3	8	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benny Harris
13. Birthplace ?

MOTHER
14. Maiden Name Mattie Coleman
15. Birthplace ?

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28-48 (month) (day) (year)
(c) Cemetery or crematory
Location Columbia, D. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1700 Bluntly ave

19 OCT 28 1948 (Date received by Registrar) Huntington Woodlawn, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1948, at 5 EDT P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1948, to 10-25 1948, and that I last saw him alive on 10-25 1948

Immediate cause of death UNDETERMINED — CERTIFICATION APPROVED BY

Due to

Due to _____ M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

Other Conditions SPONTANEOUS PNEUMOTHORAX - ? PULMONARY TUBERCULOSIS
(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: NONE PERFORMED

of autopsy: NONE PERFORMED

Duration
UNKNOWN

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide NO
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature C.L. Leyton, M.D.
Address c/o Johns Hopkins Hosp. Date signed 10-25-48

VS 193 Certificate to be Approved by Medical Examiner

Physicians: please write the causes of death clearly and legibly. Physician is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Harding
3805 Belair

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 668080

668080

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5414 Gerland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5414 Gerland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Herbert White

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-9933

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Emma B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 20, 1898

8. AGE: Years	Months	Days	If less than one day
50	8	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Purchasing Agent
11. Industry or business Gen. Ship Rep. Co.

FATHER
12. Name Frederick White
13. Birthplace Md.

MOTHER
14. Maiden Name Rose Gibbons
15. Birthplace Washington, D.C.

16 (a) Informant Mrs. Emma White
(b) Address 5414 Gerland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) OCT 28 1948 (Date received) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27th 1948, at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from: March 1948 to Oct 27 1948 and that I last saw him alive on Oct 26 1948

Immediate cause of death Ch myocarditis — Duration 8 mos

Due to Arterio-Sclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify two places)
(e) Means of injury

23. Signature J S Harding M. D.
Address 3805 Belair Rd Date signed Oct 27/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68081

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument Sts
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Pr Geo
(c) City or town Greenbelt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6A Crescent Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille Rhadi

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bert -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-15-96

8. AGE: Years 53 | Months 0 | Days 13 | If less than one day hr. min.

9. Birthplace Utah
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Carl Anderson -
13. Birthplace

MOTHER 14. Maiden Name Christina Jacobson
15. Birthplace

16 (a) Informant Friends
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 30 48 (month) (day) (year)
(c) Cemetery or crematory Fort Lincoln
Location Hyattsville Md.

18 (a) Funeral director Wm. J. F. Hines
(b) Address 2201 14th St N.W. Washington D.C.

19 OCT 29 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1948, at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1948 to Oct 28 1948 and that I last saw him alive on Oct 28 1948.

Immediate cause of death: Intestinal obstruction — Duration

Due to Extensive carcinomatosis

Due to Carcinoma of cervix

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 20th October

Major findings of operation: Extensive carcinoma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Watt

Address Johns Hopkins Hosp. Date signed Oct 28 1948

VS 133

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 157 G68082 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town Elmira (If outside city or town limits, write RURAL and give town)
(d) Street No. 379 Warwick St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cynthia Straub

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-8-46

8. AGE: Years	Months	Days	If less than one day
2	4	20	hr. min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Straub
13. Birthplace N. Y.

MOTHER
14. Maiden Name Ramona M. Hall
15. Birthplace N. Y.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/48 (month) (day) (year)
(c) Cemetery or crematory
Location Syracuse, N. Y.

18 (a) Funeral director John A. Mitchell & Son Inc
(b) Address 1900 Eutaw Place

19 (a) OCT 29 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1948, at 4.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27 1948, to 10-28 1948, and that I last saw her alive on 10-28 1948.

Immediate cause of death Cardiac Failure — Duration
Due to Angiocardiography with Luminal
Due to
Other Conditions Pulmonic Stenosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Cohen M. D.
Address John Hopkins Hosp Date signed 10-29-48

VS 199

668083

BC-48-23317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

668083 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County newborn
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 S. Conwall Ste
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Oliver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1948

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Church Home & Hospital
(Town, county, and state)

10. Usual Occupation newborn

11. Industry or business

FATHER
12. Name LLOYD OLIVER
13. Birthplace Virginia

MOTHER
14. Maiden Name VIRGINIA MILLER
15. Birthplace Maryland

16 (a) Informant Mother
(b) Address 406 S. Conwall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director John B Connelly
(b) Address 410 Eastern Ave

19 OCT 29 1948 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1948, at 10:23 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 27 1948, to Oct. 28 1948, and that I last saw him alive on Oct 28 1948.

Immediate cause of death	Duration
Unknown	
Due to Bilateral adrenal hemorrhage	
Due to Left pneumothorax	
Other Conditions Rt. upper lobe atelectasis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard M. Garrett
Address Church Home & Hosp Date signed 28 Oct 48

VS :53

G68034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 ✓ G68084 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2908 Presbury St.
(c) Hospital or institution: 15.06

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Presbury St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD A. LONG. ✓

3 (b) If veteran, name war none.

3 (c) Social Security Account No. none.

4. Sex male. | 5. Color or race White. | 6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October-15-1875

8. AGE: Years 73 | Months 0 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland. (town, county, and state)

10. Usual Occupation Book Keeper.

11. Industry or business

PARENTS
12. Name Otto Long.
13. Birthplace Germany.

MOTHER
14. Maiden Name Mary Mikael.
15. Birthplace Germany.

16 (a) Informant Mrs. Mildred Mueller.
(b) Address 2908 Presbury St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Oct. 29-48. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512-Frederick, Ave.

19 OCT 29 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October, 26- 1948. at 9.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1948. to Oct 26 1948.
and that I last saw him alive on Oct 26 1948.

Immediate cause of death Lober pneumonia — Duration

Due to

Due to

Other Conditions Chronic Cardio Ve, disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emmett D. Kane M. D.
Address 736-Pop's St Date signed 10-29-48

V S 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The [illegible] every item of information should be carefully supplied.

68085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 668085

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 10-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sr. M. Maurelian Walter

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1898

8. AGE: Years	Months	Days	If less than one day
50	5	13	hr. min.

9. Birthplace Penn. (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER 12. Name	Georg Walter
13. Birthplace	Germany
MOTHER 14. Maiden Name	Mary Anna Obach
15. Birthplace	Germany

16 (a) Informant Sr M Rosita
(b) Address 901 Aisquith St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 48 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Gen Section
18 (a) Funeral director Geo M Frankhouser
(b) Address 611 W Lafayette Ave
19 (a) Oct 29 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28 1948 at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1948, to 10-28-1948, and that I last saw her alive on 10-28 1948.

Immediate cause of death Acute Cardio-Respiratory Failure — Duration

Due to Uremia

Due to Carcinoma of left breast (Operated on 5yrs ago) with metastasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinomatosis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Clyde D. Thomas, M.D.
Address Mercy Hospital Date signed 10-28-48

VS 150

68086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68086

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 155 Jenney St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred M Myers

3 (b) If veteran, name war: Spanish Amer.

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife: Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12. 1876

8. AGE: Years 72 | Months - | Days 26 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Plumber - Retired

11. Industry or business

FATHER
12. Name ? Myers
13. Birthplace Balto Md

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Balto Md.

16 (a) Informant Mrs. Wm Hostetter
(b) Address 15 S. Janney St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-48 (month) (day) (year)
(c) Cemetery or crematory Balto Nat Cem
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

1948 OCT 29 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1948 at 7:05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inquest thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute pulmonary Edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Kelleher M.D. Medical Examiner.
Date signed Oct 28, 1948

68087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68087

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2035 Gough St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos. or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2035 Gough St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank R. Foster

3 (b) If veteran, name war: World I.
3 (c) Social Security Account No.

4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: W.
6 (b) Name of husband or wife: Theresa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 2-1894

8. AGE: Years 54 | Months 2 | Days 26 | If less than one day: hr. min.

9. Birthplace: Glen Burnie Md (Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business

FATHER
12. Name: Charles Foster
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Watts
15. Birthplace: Md.

16 (a) Informant: Margaret Andros
(b) Address: 2030 Gough St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-1-48 (month) (day) (year)
(c) Cemetery or crematory: Balto. Nat. Cem.
Location: Baltimore

18 (a) Funeral director: Wm Cook Inc
(b) Address: 1217 St Paul St

(a) Date received: OCT 29 1948 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 28 1948, at 10:30 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cirrhosis of liver

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: William J Helfrich M.D. Medical Examiner.
Date signed Oct 28, 1948

G68088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No. G68088

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens + Caton Aves

(c) Hospital or institution: St. Agnes Hospital No

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3/4 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 210 N. Fulton Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Nan B. Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. 228-12-9788

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Claude J Brown

6 (c) If divorced, give date years

7. Birth date of deceased (mo., day, yr.) [illegible] 1884

8. AGE: Years 62 | Months 7 | Days 29 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Robert Ford (deceased)

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Mary Jacobs (deceased)

MOTHER 15. Birthplace Md

16 (a) Informant Talmadge J Brown

(b) Address 210 N Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30-48 (month) (day) (year)

(c) Cemetery or crematory Chester Cem

Location Chestertown Kent Co Md

18 (a) Funeral director Edmond Foulson

(b) Address 2253 W Baltimore Blvd

19 (a) [illegible] (b) Funeral Director for Williams, M.D. Registrar

Date received by Local Registrar OCT 29 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27 1948 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27-48 to 10-27-48 and that I last saw her alive on 10-27-48

Immediate cause of death Cardio-respiratory failure — Duration

Due to Pneumonia - Contributing

Due to

Other Conditions Chronic bronchial asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Sidney Johnson Vansant Jr. M.D. M.D.

Address St. Agnes Hospital Date signed 10/27/48

68089 BC-48-15126

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

Registered No. 68089

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital W 7-08
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5803 Clearspring Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cleta Frainie (Infant) CORRIGAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1948

8. AGE: Years	Months	Days	If less than one day
	3	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name James Henry Corrigan
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Cleta Frainie
15. Birthplace Baltimore, Md.

16 (a) Informant: James H. Corrigan, Jr.
(b) Address 5803 Clearspring Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month, day, year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore, Md.

18 (a) Funeral director H.W. Mears & Son
(b) Address 805 N. Calvert St.

OCT 29 1948 (Date rec'd by registrar) (Signature of registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1948, at 4.30 PM

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suffocation due to Obstruction of bronchi due to aspiration of vomitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work?)
(d) Means of injury

23. Signature George G. Merrill M.D. (Medical Examiner)
Date signed 10/28/48

VS 151

68090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932

Registered No. 68090

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 Ensor Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 Ensor Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Loveday

3 (b) If veteran, name war: World I War

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Sign Painter

11. Industry or business

FATHER
12. Name Charles Loveday
13. Birthplace Maryland

MOTHER
14. Maiden Name Carrie Dashields
15. Birthplace Maryland

16 (a) Informant: Emma Browne
(b) Address 1613 E. Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month, day, year)
(c) Cemetery or crematory Balto. National
Location 5501 Frederick Ave.

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 1364 N. Central Ave

19 (a) OCT. 29 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION 15

20. DATE OF DEATH October 27, 1948, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.
Date signed 10-28-48

G68091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C ✓ Registered No. G68091

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Md. General Hospital 13 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE ROBERTA BOSWORTH

3 (b) If veteran, name war

3 (c) Social Security Account No. 299-05-2614

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wilbur McKnew Bosworth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1878

8. AGE: Years 70 | Months 6 | Days ?? | If less than one day hr. min.

9. Birthplace: Kennedyville, Maryland
(Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: Linen Thread Co., Inc.

FATHER
12. Name: Robert Loud
13. Birthplace: Caroline Co., Md.

MOTHER
14. Maiden Name: Mary Jane Yeates
15. Birthplace: Delaware

16 (a) Informant: Mr. J. Alfred Bosworth
(b) Address: 2036 Park Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-30-48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: Baltimore, Maryland

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1948, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fat embolism
due to multiple fractures

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 13 ✓
(a) Date of injury Oct. 25/48 6:15 P.M.
(b) Where did injury occur? North Ave. & Park Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian struck by auto.

23. Signature Emil L. Kyle M.D.
Medical Examiner

Date signed 10/28/48

VS 151

8092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a ✓

Registered No. 68092

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1721 Bolton St.
(c) Hospital or institution: 1401
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Bolton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRISON BRENT

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
World War #1	212-01-1552	male	white	married

6 (b) Name of husband or wife Mary Louise Brent
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1882

8. AGE: Years	Months	Days	If less than one day
66	4	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business

FATHER
12. Name Hugh Brent
13. Birthplace The Plains, Va.

MOTHER
14. Maiden Name Sarah Bull
15 Birthplace Balto., Md.

16 (a) Informant Mrs. Mary L. Brent
(b) Address 1721 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1948 at 1:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Oct. 1948 to 28 Oct. 1948.
and that I last saw him alive on 27 Oct. 1948.

	Duration
Immediate cause of death Uremia	17 days
Due to Nephritis & Hypertension	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Douglas Lockard M. D.
Address 802 Cathedral St. Date signed 29 Oct, 1948

VS 150

668093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94

Registered No. 668093

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 13-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Newington Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claude S. Nye

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth McCafferty

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1906

8. AGE: Years 42 (est) | Months 8 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Gloucester County, (Pa) Va. (Town, county, and state)

10. Usual Occupation Sales-manager

11. Industry or business Talbot Motors

FATHER
12. Name Louis B. Nye
13. Birthplace Gloucester County, Va.

MOTHER
14. Maiden Name Eleanor Fox
15. Birthplace Gloucester County, Va.

16 (a) Informant Mrs. Elizabeth McC. Nye
(b) Address 705 Newington Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Memorial
Location Washington Blvd. at Dorsey, Md.

18 (a) Funeral director John O. Mitchell & Sons Inc
(b) Address 1900 Eutaw Place, Balto., Md.

OCT 29 1948

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1948, at 9:55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/28/48

VS 151

68094

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68094

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 Carroll Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Carroll Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth P. Fields

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-1770

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1898

8. AGE: Years	Months	Days	If less than one day
50	6	7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation re-cutter

11. Industry or business B.V.D. Corporation

FATHER
12. Name James E. Fields
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Virginia Hennenberger
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Marjorie Jurkewitz
(b) Address Baltimore, Maryland

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) OCT 29 1948 (b) Huntington Williams, M.D. Registrar
(Do not write in this space)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1948, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1946 to 10/27 1948, and that I last saw h alive on 10-27 1948.

Immediate cause of death: Carcinoma of Ovary — Duration: 2 yr

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Aug 5, 1948

Major findings of operation: Carcinoma of ovary

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John P. Unlock, Jr. M.D.
Address 1252 Wash Blvd Date signed 10-29-48

VS 150

68095

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1864 — Registered No. G68095

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 Bonaparte Ave
(c) Hospital or institution: 9-08

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 Bonaparte Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Bonhage

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Herman Bonhage
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23-1859

8. AGE: Years 89 | Months 5 | Days 4 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name — Bonhage
FATHER 13. Birthplace Germany
MOTHER 14. Maiden Name ?
MOTHER 15. Birthplace Germany

16 (a) Informant Mr. Bonhage
(b) Address 1041 Bonaparte Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Philip Herring Sons
(b) Address 2024 Orleans St

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Signature of registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1948, at 2 09 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1948 to Oct 27 1948, and that I last saw h[illegible] alive on Oct 26 1948.

Immediate cause of death: Bronchopneumonia
Duration: 10 days
Due to: myocardial failure
Duration: Oct 1/4
Due to: arteriosclerosis.
Due to —
Other Conditions: Emphysema
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9-08
(a) Accident, ~~suicide, or homicide~~ accident
(b) Date of occurrence Oct 11 1948 at 5:30 P.M.
(c) Where did injury occur? Bath Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, ~~on farm, industrial place, in public place~~? (Specify type of place) Home - Sitting room While at work? No.
(e) Means of injury: Fracture neck of left femur
23. Signature Chas F. Hammond M.D.
Address 722 No Kenwood Ave Date signed Oct 25 48

Tripped - fell in room - falling on left side

G68096

G68096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. AB-124110

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5416 Gerland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Mary Wekenman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?

8. AGE: Years 75 or ?? | Months | Days | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation ? none

11. Industry or business

FATHER
12. Name Hugh Cox
13. Birthplace Ireland

MOTHER
14. Maiden Name Rosana McClleand
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 19 48 at 10.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27- 19 48 to 10-27- 19 48. and that I last saw h or alive on 10-27- 19 48

Immediate cause of death: Cerebrovascular accident — Duration: 1 week

Due to

Due to

Other Conditions: pulmonary infarction — Duration: 1 Day
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E. Reichold M. D.
Address Balto City Hosp. Date signed 10-28-48

VS 150

Burial ✗

68097

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1938 Registered No. 68097

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004 [redacted] Sqauth St.
(c) Hospital or institution: At home 10-31
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 N. Asquith ST (If rural give location)
(e) Citizen of foreign country? NO Yes or No
If yes, name country

3 (a) FULL NAME William NAUMANN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife LOUISA NAUMANN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 6, 1878

8. AGE: Years	Months	Days	If less than one day
70	5	20	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation MARITIME POLICE
11. Industry or business

FATHER
12. Name JOHN NAUMANN
13. Birthplace MD.

MOTHER
14. Maiden Name MARY SPRICK
15. Birthplace GERMANY

16 (a) Informant MRS LOUISA NAUMANN
(b) Address 1004 N. ASQUITH ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11/1/38 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location BALTIMORE MD

18 (a) Funeral director ULLRICH FUNERAL HOME
(b) Address 2006 ORLEANS ST.

19 (a) OCT 29 1938 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1938, at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 19 1937 to October 28 1938, and that I last saw h IM alive on October 28 1938

Immediate cause of death	Duration
CARDIAC FAILURE	1 DAY
Due to CHRONIC MYOCARDITIS & MYOCARDIAL DEGENERATION	4 YEARS
Due to ARTERIOSCLEROSIS	4 YRS PLUS 3 YRS.
Other Conditions Senile dementia mild (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin M. Borden M. D.
Address 2030 W. Fayette St Date signed 10/29/38

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 58098

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2023 Druid Hill Ave.
(c) Hospital or institution: 14-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Goode

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1897

8. AGE: Years 51 | Months 4 | Days 8 | If less than one day: hr. min.

9. Birthplace Cincinnati, Ohio (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Charles L. Goode
13. Birthplace Cincinnati, Ohio

MOTHER
14. Maiden Name Lora Bundy
15. Birthplace Richmond, Va.

16 (a) Informant Mrs. Mary Goode Married
(b) Address 2023 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lee A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Oct 29 1948 (Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1948 at 2:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1948 to 10/28 1948, and that I last saw h[illegible] alive on 10/28 1948.

Immediate cause of death: Cerebral-Apoplexy — Duration
Due to: Paralysis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:
If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature Ben R. Lutts M. D.
Address 2139 Druid Hill Ave. Date signed 10/29/48

VS 150

Please correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

68099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68099

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Fairfield (If outside city or town limits, write RURAL and give town)
(d) Street No. 3317 Duvall St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH CAMPBELL

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 — 1904

8. AGE: Years	Months	Days	If less than one day: hr.	min.
44	7	—		

9. Birthplace Laborer (Town, county, and state)
10. Usual Occupation West Moreland Co. Va.
11. Industry or business

MOTHER / FATHER
12. Name Richard Campbell
13. Birthplace Va.
14. Maiden Name Betty Johnson
15. Birthplace Va

16 (a) Informant Walter Garner
(b) Address 33 E. Sharpnack St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/48 (month, day, year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pressman St.

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1948, at 3 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10-7 1948 to 10-25 1948, and that I last saw h alive on 10-25 1948

Immediate cause of death: Subarachnoid Hemorrhage — Duration 12 hrs

Due to: Hypertension & Arteriosclerosis Cardiovascular Disease — Duration years

Due to:

Other Conditions: Syphilis — Duration years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Subarachnoid Hemorrhage

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward A. Newell, M.D.
Address 1213 Light St. Date signed 10-29-48

PHYSICIAN: Underline the cause to which death should be charged statistically.

VS 150

68100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2500 Manhattan Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Manhattan Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME W. Lawrence Summers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Virginia E. Summers 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1880

8. AGE: Years	Months	Days	If less than one day
68	0	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Florist.
11. Industry or business

FATHER
12. Name John L. Summers
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Roxanna E. Oliver
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Virginia E. Summers
(b) Address 2500 Manhattan ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore Md.

18 (a) Funeral director Mamie Cook Syfer
(b) Address 1600 W. North ave.

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1948, at 4-40 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 5 1948 to Oct. 27 1948, and that I last saw him alive on Oct. 28 1948.

Immediate cause of death	Duration
Carcinoma Entire lung with throat involvement	10 mo.
Due to Cancer	6 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation June 25/48
Major findings of operation: Epidermoid carcinoma left lung
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?) (Specify type of place)
(e) Means of injury

23. Signature Vernon C. Wantz M.D.
Address 2501 Manhattan Ave. Date signed 10/28/48

VS 150

88101

BALTIMORE CITY HEALTH DEPARTMENT

B.C. 48-23979

CERTIFICATE OF DEATH 159

Registered No. 168101

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town White Hall, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Baublitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 27, 1948

8. AGE: Years	Months	Days	If less than one day
		one	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Charles Baublitz
13. Birthplace Towson, Md.

MOTHER
14. Maiden Name Gertrude Almony
15. Birthplace Parkton, Md.

16 (a) Informant Gertrude Baublitz
(b) Address White Hall, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-48 (month) (day) (year)
(c) Cemetery or crematory D. Yeagy Branch
Location Harford Co. Md

18 (a) Funeral director Landon M. Brooks
(b) Address Bel Air, Md.

19 (a) OCT 30 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1948, at 6 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1948, to 10/28 1948, and that I last saw her alive on 10/28 1948.

Immediate cause of death
Convulsion
Asphyxia
Due to unknown

Due to

Other Conditions Prematurity
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P.A. Peterson M. D.
Address University Hosp Date signed 10/28/48

VS 150

161a

68102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X Y 68102 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 105 days
(e) Length of stay in Baltimore (yrs., mos., or days) 105 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 S. 5th St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JULIUS ALBERT CUNHA

3 (b) If veteran, name war USA- 1921

3 (c) Social Security Account No. 199-01-4652

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Mar

6 (b) Name of husband or wife Ella Cunha

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1896

8. AGE: Years	Months	Days	If less than one day
52	2	12	hr. min.

9. Birthplace Portugal (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Seafarer

FATHER
12. Name Manuel Cunha
13. Birthplace Portugal

MOTHER
14. Maiden Name Rosa Costa
15. Birthplace Portugal

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-31-48 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location [illegible]

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) OCT 29 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1948 at 1:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jul. 13 1948 to Oct. 26 48 and that I last saw him alive on Oct. 26 1948.

Immediate cause of death
1- Carcinoma of bladder
2- Necrosis and infection of
Due to bladder wall

Duration 1 yr.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation March 4, 1948

Major findings of operation: Carcinoma of bladder

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 10/29/48 M. D.

VS 199

X

Please see that every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932

Registered No. 68103

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3110 Fleet Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 3110 Fleet Street. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lena Schuman Zimek

3 (b) If veteran, name war

3 (c) Social Security Account No. one

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/5/76

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72	1			

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business Domestic

FATHER

12. Name Unknown

13. Birthplace

MOTHER

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mary Fisher

(b) Address 3110 Fleet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location German Hill Rd.

18 (a) Funeral director Lilly & Zeiler, Inc.,

(b) Address 403 S. Wolfe Street

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Huntington, Millcreek, Md. Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH 10/27/ 1948, at 4.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 4 1948 to OCT. 27 1948. and that I last saw her alive on OCT. 27 1948.

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 10/4/48

Due to ARTERIOSCLEROTIC, HYPER-

Due to TENSIVE CARDIO-VASCULAR ??? DISEASE

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature Joseph F. Braga M. D.

Address 209 E. Chester St. Date signed 10/28/48

VS 150

8:04

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. 668:04

Please write clearly and legibly. Use black ink. Do not use pencil. Do not fold. Do not write outside the lines. Be sure the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 801 S. Lakewood Avenue

(c) Hospital or institution: 1-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 801 S. Lakewood Avenue (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME JACOB C. LUEBBEN

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 214-03-4029

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	married

6 (b) Name of husband or wife Carrie D'Ambrosia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/24/88

8. AGE: Years	Months	Days	If less than one day
59	10	✓	hr. min.

9. Birthplace Baltimore

10. Usual Occupation Shipping Clerk

11. Industry or business

FATHER 12. Name Chas. Luebben

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth ?

15. Birthplace Germany

16 (a) Informant Carrie Luebben (wife)

(b) Address 801 S. Lakewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location German Hill Road

18 (a) Funeral director Lilly & Zeiler, Inc.

(b) Address 403 S. Wolfe Street

19 (a) OCT 29 1948 (b) Huntington, Williamsport

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH 10/ 26/ 1948, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1948 to Oct. 26 1948, and that I last saw him alive on Oct. 23, 1948.

Immediate cause of death	Duration
Chronic mitral regurgitation	?
Due to Chronic myocarditis	10 months
Due to Coronary thrombosis	3 days
Due to Chronic bronchitis, bilat.	?
Other Conditions Arterio-sclerosis	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature J. B. Bromukas, M.D.

J. Benedict Bromukas, M.D.

Address 3037 O'Donnell St Date signed OCT 28 1948

668:05

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668:05

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Crisfield (If outside city or town limits, write RURAL and give town)
(d) Street No. Myrtle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Alice T. Schwatka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Dr. CharlesT.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1883

8. AGE: Years 65 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace: Montgomery County, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Robert Assa Gladmon
13. Birthplace: Montgomery County, Md.

MOTHER
14. Maiden Name: Augusta Virginia Glover
15. Birthplace: Montgomery County, Md.

16 (a) Informant: Mrs. Dorothy Kellanr
(b) Address: Crisfield, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-48 (month) (day) (year)
(c) Cemetery or crematory: Sunny Ridge Memorial Park
Location: Crisfield, Maryland

18 (a) Funeral director: Bradshaw Funeral Parlors
Crisfield, Maryland

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29, 1948 at 4:20A. M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial plant, in public place? While at work?
(d) Means of injury

23. Signature: Wesley R. Davis M.D. Medical Examiner.
Date signed 10-29-48

VS 151

668:06

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668:06

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3009 E. Balt. St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Riefner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Louis Riefner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 21, 1861

8. AGE: Years 87 | Months X | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Bleitsman
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Mrs Lillian Dunlop
(b) Address 3009 E. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location

18 (a) Funeral director John A. Morar
(b) Address 3060 E. Balt St.

19 (a) OCT 29 1948 (Date rec'd by registrar) Huntington Williams, Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1948, at 12:01 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Oct 28 1948, and that I last saw her alive on Oct. 28 1948.

Immediate cause of death: Hypostatic pneumonia — Duration: 4 wks

Due to

Due to

Other Conditions Epithelioma face

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles L. MacMenamin M. D.
Address 2911 E. Balt. St. Date signed Oct 29, 1948

VS 150

111 c

Certificate Corrected 11-19-49. ✓

G68:07

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No. G68:07

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hospital (D.O.A.)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 Woodland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas A. Copenhaver

3 (b) If veteran, name war 88********

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Catharine R.

6 (c) If alive, [illegible] age years

7. Birth date of deceased (mo., day, yr.) April 30, 1894

8. AGE: Years 54 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Sunbury, Pa.
(Town, county, and state)

10. Usual Occupation Designing Eng
11. Industry or business Crown Cork & Seal

FATHER
12. Name Anson Copenhaver
13. Birthplace Pa.

MOTHER
14. Maiden Name Emma Jane Mutschler
15. Birthplace Pa.

16 (a) Informant: Mrs. Catharine Copenhaver
(b) Address 3405 Woodland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-48 (mo.)

(c) Cemetery or crematory Sandy Mount M-Church
Location Sandy Mount, Carroll Co. Md.

18 (a) Funeral director LORING BYERS
(b) Address 5005 Park Heights Ave.

19 (a) OCT 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26th/48 19 8:50 P M

21. I certify that I took charge of the remains described above, held an Autopsy on Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? (While at work)
(d) Means of injury

23. Signature John R. Dawson M.D.
Medical Examiner.
Date signed 10/27/48

VS 181

68108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940 Registered No. 68108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21-18
(c) Hospital or institution Md. Gen'l Hosp DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and the town)
(d) Street No. 5228 Wilton Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl S. Hart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret L. (Owen)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1892

8. AGE: Years 56 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Blyesville, Harford Co. Md
(Town, county, and state)

10. Usual Occupation Fireman Fireman

11. Industry or business Lumber Sash & Blinds

FATHER
12. Name Harry C. Hart
13. Birthplace Savannah, Ga.

MOTHER
14. Maiden Name Anna E. Street
15. Birthplace Harford Co. Md.

16 (a) Informant Mrs Margaret L. Hart
(b) Address 5228 Wilton Heights Ave

17 (a) Burial (b) Date thereof 10-30-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olive
Location Randallstown Md

18 (a) Funeral director Irving Byers
(b) Address 5005 Belair Rd

1948 OCT 29 1948
(Date received by registrar) Herrington for Williams M.D.

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1948, at 1:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions Acute Pulmonary Edema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23 Signature William G Kelsch M.D.
Medical Examiner.
Date signed Oct 28, 1948

2815 Mayne Falls Md.

68:09

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 68:09

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2813 W. North Ave.
(c) Hospital or institution: 15.66
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 W North (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank B Reed

3 (b) If veteran, name war ~

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Sabilla Wolfe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 7 1860

8. AGE: Years 88 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Fredericksburg Pa. (Town, county, and state)

10. Usual Occupation Handy Man

11. Industry or business

FATHER 12. Name Franklin Reed
13. Birthplace Fredericksburg Pa

MOTHER 14. Maiden Name Lydia Bricker
15 Birthplace Fredericksburg Pa.

16 (a) Informant Mrs. Frank B Reed
(b) Address 2813 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 - 48 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill
Location Fredericksburg Pa

18 (a) Funeral director Ellsworth Chynoweth
(b) Address 3911 Liberty Heights Ave

19 (a) OCT 29 1948 (Date rec'd by registrar) Huntington Williams Mgr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1948, at 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1948 to Oct 1948 and that I last saw him alive on Oct 26 1948

Immediate cause of death	Duration
Acute nephritis & uremia	2 weeks
Due to Arteriosclerotic Cardio-Vascular disease	?
Due to	
Other Conditions Chronic Nephritis	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Daniel K Robinson M. D.
Address 2835 Garrison Blvd Date signed 10/29/48

Daniel K. Robinson

VS 152

68110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 a

68110 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1525 Church St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Curtis Bay (If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 Church St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis B. Mallonee

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie Cecelia
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) May 26, 1895

8. AGE: Years	Months	Days	If less than one day
63 54	5	0	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER
12. Name Brice Mallonee
13. Birthplace Md

MOTHER
14. Maiden Name Sallie Martin
15. Birthplace Virginia

16 (a) Informant Mrs Marie Mallonee
(b) Address 1525 Church St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F Denny Inc
(b) Address 715 Light St

19 (a) OCT 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1948, at 12 N A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug / 1947, to Oct. 26 1948. and that I last saw him alive on Oct. 27 1948.

Immediate cause of death Pulmonary Hemorrhage — Duration 1 hour

Due to Metastatic Malignancy to Lungs

Due to Carcinoma of Rt. Kidney

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of Rt Kidney

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify one of these) While at work?
(e) Means of injury

23. Signature Carl Mallonee

Address 320 Dalrymple Ave Date signed 10/23/48 M.D.

VS 15

G68111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 15

Registered No. G68111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 N. Payson St.
(c) Hospital or institution: 16-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 N. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Conway Shepard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Maried

6 (b) Name of husband or wife Mrs. Mollie Shepard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 31 1892

8. AGE: Years	Months	Days	If less than one day
55	9	25	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Schauffuer
11. Industry or business

FATHER
12. Name Allen Sheapard
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Latten
15. Birthplace Virinia

16 (a) Informant Mrs. Mollie Shepard
(b) Address 1013 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Arbutus Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave

OCT 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1948 at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 1948 to Oct. 26 1948. and that I last saw him alive on Oct 26 1948

Immediate cause of death Cancer of Stomach — Duration ?

Due to

Due to

Other Conditions None
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 844 N Carey St. Date signed 10/28/48

VS 150

68112

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

166 Registered No. 68112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital 3-0 V
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 16 days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 1147 E. Lombard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADAM GREEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 29 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Christopher Gre[illegible]
13. Birthplace Virginia

MOTHER
14. Maiden Name Hester ?
15. Birthplace Gloster Co., Va.

16 (a) Informant: Arthur Green (brother)
(b) Address 1114 E. Lombard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30-48 (month, day, year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Brooklyn Md

18 (a) Funeral director Elmer O. Wilson
(b) Address 1000 Boundary Ave

19 OCT 29 1948 (Date rec'd by registrar) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1948 at 9:40 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet-wound of brain

Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-10-48 1:0[illegible] P. M.
(b) Where did injury occur? In Front of [illegible] Colfax Way, Dundalk, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Firearms

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10/29/48

VS 151

68113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days (Present admission)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3625 Kimble Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Segwalt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Lucie E. Segwalt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1887

8. AGE: Years 61 | Months 5 | Days 0 | If less than one day: hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Accountant (Retired)

11. Industry or business Alemite Co. of Md.

FATHER
12. Name John Segwalt
13. Birthplace N. Y.

MOTHER
14. Maiden Name Elizabeth Hartel
15. Birthplace N. Y.

16 (a) Informant Mrs. Lucie E. Segwalt
(b) Address 3625 Kimble Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. Funeral Home, Baltimore, Md.

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1948 at 11 53 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 10, 1948 to Oct. 28 1948 and that I last saw h/m alive on Oct. 28 1948.

Immediate cause of death Cachexia — Duration

Due to Osteogenic sarcoma of Right ilium with generalized metastasis — 6 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J. Brady M. D.
Address Md. Gen. Hosp. Date signed 10-28-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The correct name, address, and other information should be carefully supplied.

VS 150

G68114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68114

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. This certificate should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4504 Prospect Circle (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLSWORTH THOMAS MEAD

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Lavinia Augusta Mead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1886

8. AGE: Years 62 | Months 5 | Days 5 | If less than one day: hr. min.

9. Birthplace: Brooklyn, N. Y. (Town, county, and state)

10. Usual Occupation: Toolmaker

11. Industry or business

FATHER
12. Name: Ellsworth Mead
13. Birthplace: N. Y.

MOTHER
14. Maiden Name: Josephine Clark
15. Birthplace: N. Y.

16 (a) Informant: Miss Grace E. Mead
(b) Address: 4504 Prospect Circle

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1, 1948 (month) (day), (year)
(c) Cemetery or crematory: Balto. Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29/48 19 . at 12:07 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22/48 19 . to 10/29/48 19 . and that I last saw h/m alive on 10/29 1948.

Immediate cause of death: Respiratory failure — Duration

Due to cerebral edema

Due to Aortic stenosis due to arteriosclerosis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence none at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. P. Young M. D.
Address W. Balto Baltimore Date signed 10/29/48

VS 190

68115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No. 68115

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2831 Restman St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME McGowan, Irene
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife: Morrison McGowan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1882

8. AGE: Years	Months	Days	If less than one day
66	0	18	hr. min.

9. Birthplace: Woodstock, Maryland (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: Gustavus Brown
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Annie E. Frost
15. Birthplace: Maryland

16 (a) Informant: John R. Brown
(b) Address: 9 Yorkway, Dundalk

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory: St. John's
Location: Ellicott City, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) OCT 29 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1948 at 7:20 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10-21 1948 to 1949 and that I last saw her alive on 10-28 1948

Immediate cause of death: Cerebral Thrombosis — Duration: 4 days
Due to: Hypertensive Arteriosclerotic Cardiovascular Disease — Duration: years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Cerebral Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Edward L. Powell, M.D.
Address: 1213 Light Street Date signed: 10-29-48

VS 150

668116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. 668116

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3530 Hickory Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ~~Daniel~~ Father E. Baggett

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 217-22-2231

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 18, 1927

8. AGE: Years	Months	Days	If less than one day
21	4	10	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Traffic Clerk

11. Industry or business S. Shapiro & Sons

FATHER
12. Name John H. Baggett
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Bertha M. Griffith
15. Birthplace Baltimore, Maryland

16 (a) Informant John V. Baggett
(b) Address 3530 Hickory Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) OCT 29 1948 (Date rec'd by registrar) (b) Huntington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1948, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28 1948 to Oct 28 1948, and that I last saw h[illegible] alive on Oct 28 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Rheumatic C-V disease mitral stenosis (Enter but one)	
Due to Acute left sided failure 2 supervened	
Other Conditions pneumonitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Johnson Verrill Jr. MD
Address St. Agnes Hospital Date signed M. D. 10/29/48

VS 150

68117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68117

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S Norris St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MR. WILLIAM A. BROMWELL

3 (b) If veteran, name war None | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mary Bromwell
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 11-30-72

8. AGE: Years	Months	Days	If less than one day
75	10	29	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Hotel business

FATHER 12. Name Robert Bromwell
13. Birthplace Md.

MOTHER 14. Maiden Name Melinda Wolford
15. Birthplace Md

16 (a) Informant wife
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1-1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Balto Md
Pratt & B.M. Walter
18 (a) Funeral director Pratt & Stucks
(b) Address Pratt & Stucks

19 (a) OCT 29 1948 (Date rec'd by registrar) Registrar Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29-1948 at 12:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20-1948 to 10-29-1948 and that I last saw him alive on 10-29-1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Thrombosis	10 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allyn P. Judd M. D.
Address Mercy Hospital Date signed 10-29-48

Allyn P. Judd. +

VS 189

668118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 d Registered No. 668118

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1000 Eutaw Avenue

(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Mos. 7 Days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 317 E. Augusta Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Emma Neville

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Joseph E. Neville

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) JAN. 29-1873

8. AGE: Years	Months	Days	If less than one day
75	9	28	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business At Home

FATHER 12. Name Ferdinand A Bonhage

13. Birthplace Germany

MOTHER 14. Maiden Name Josephine Ebute

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ford A. Neville, Son

(b) Address 155 E. Augusta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29-48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore Md

18 (a) Funeral director C. B. Wisbert & Son

(b) Address 1301 Eutaw Place

19 OCT 29 1948 (Date rec'd by registrar) (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1948 at 8 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/1948 to 10/26 1948, and that I last saw h alive on 10/26 1948.

Immediate cause of death Cardio-Resp Failure — Duration

Due to Acute Coronal Thrombosis

Due to Hypertension & C-V Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edward L. Parker Jr. M. D.

Address Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

VS 150

G68119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68119

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St.
(c) Hospital or institution:
Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Same
(a) State Md. (b) County Curtis Bay
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Orchard Beach
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Carbary

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 129-05-0964

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jeanette (wife)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 1921

8. AGE: Years 27 | Months 4 | Days 15 | If less than one day: hr. min.

9. Birthplace Conn.
(Town, county, and state)

10. Usual Occupation Installator

11. Industry or business

FATHER
12. Name Thomas Carbary
13. Birthplace Conn

MOTHER
14. Maiden Name Helena Fagan
15. Birthplace Conn

16 (a) Informant Jeannette Carbary (wife)
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30 48 (month) (day) (year)
(c) Cemetery or crematory Bells National Cemetery
Location Frederick Ave.

18 (a) Funeral director Krauss Funeral Home
(b) Address 1216 E. Charles St.

19 (a) Oct 29 1948 (b) Huntingtown, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26- 1948, at 3 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 1948 to 10/26 1948 and that I last saw him alive on 10/26 1948.

Immediate cause of death: Hepatic Failure — Duration

Due to: Hepatitis Infectious Acute

Due to: Cirrhosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Cirrhosis, Fatty infiltration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard K Raymond M.D.
Address Spring Grove Hosp. Date signed 10/26/48

VS 133

+ Raymond

68120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address RAYNOR AND DUKELAND AVE.
(c) Hospital or institution: WEST BALTIMORE GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town OELLA
(If outside city or town limits, write RURAL and give town)
(d) Street No. GRANITE HILL (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA VIRGINIA CAIN

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife RALPH CAIN

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) APRIL 30, 1899

8. AGE: Years 49 | Months 5 | Days 27 | If less than one day hr. min.

9. Birthplace STEPHEN'S CITY, VIRGINIA (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name MORGAN TEVAULT
13. Birthplace STEPHEN'S CITY, VIRGINIA

MOTHER
14. Maiden Name MARGARET WHITE
15. Birthplace STEPHEN'S CITY, VIRGINIA

16 (a) Informant RALPH CAIN
(b) Address OELLA, MARYLAND

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Nov 1, 1948 (month) (day) (year)
(c) Cemetery or crematory St Johns Cem
Location Ellicott City, Md.

18 (a) Funeral director Ralston Stone
(b) Address Ellicott City Md.

19 (a) OCT 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28/48 1948, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26/48 19 to 10/28/48 19 . and that I last saw her alive on 10/27/48 19 1PM

Immediate cause of death Heart failure of unknown nature

Due to Causes completely unknown.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. P. Young M.D.
Address West Balto. Bch. Hosp. Date signed 10/28/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

68121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178

Registered No. 68121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 750 W Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BRETT A. RAMSEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1893

8. AGE: Years	Months	Days	If less than one day
55	6	13	hr. min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Ramsey
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Hillman
15. Birthplace Va.

16 (a) Informant Nellie E. Williams
(b) Address 607 Bancroft Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11-1-48 (month) (day) (year)
(c) Cemetery or crematory Oakwood Mem. Location Richmond Virginia

18 (a) Funeral director John L. Miller
(b) Address 2435 E. Oliver St.

1948 OCT 30 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1948, at 6:15 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 27/48 approx. 5 P. M.
(b) Where did injury occur? Above Address
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Illuminating gas—Oven burner on but unlit

23. Signature Earl L. Royer, M.D. Medical Examiner.

Date signed 10/28/48

VS 151

68122

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 68122

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Madison ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Harry W Watson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Mary Watson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 2-1890

8. AGE: Years	Months	Days	If less than one day
58	5	5	hr. min.

9. Birthplace Salisbury Md (town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER	12. Name Alexander Watson
	13. Birthplace Md
MOTHER	14. Maiden Name Minnie Phillips
	15. Birthplace Md

16 (a) Informant Mary Watson
(b) Address 2117 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Wm J Jackson
(b) Address 916 Druid Ave

19 OCT 30 1948 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1948, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948, to Oct 27 1948.
and that I last saw him alive on Oct 27 1948.

Immediate cause of death Cardio-Nephritis (Autopsy) — Duration 10 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno. A. Julian M. D.
Address 511 N. Eutaw St. Date signed 10/28/48

VS 150

668123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 09
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS KLUG

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) AUG 25 1874

8. AGE: Years	Months	Days	If less than one day
74	2	4	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Interior Decorator
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace "

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace "

16 (a) Informant R.E. Dressell
(b) Address 3918 Ednor Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St. Baltimore, Md

OCT 30 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1948 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19 to 29 Oct 19 28, and that I last saw h alive on 22 Oct 19 48.

Immediate cause of death
Cardiac Vascular Disease
Aortic Stenosis
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
1
2
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Samuel Silverfine M.D.
Address 714 E. Preston St Date signed 29 Oct 48

VS 150

G68124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9 2 d

Registered No. G68124

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2007 Belair Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 01

(e) Length of stay in Baltimore (yrs., mos., or days) ~~3 yrs~~

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 2007 Belair Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob Dieter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married,~~ widowed, ~~or divorced~~
M	W	Widowed

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 10-1867

8. AGE: Years	Months	Days	If less than one day: hr.	min.
80	11	18		

9. Birthplace Rutty Hill Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER

12. Name Charles Dieter

13. Birthplace Rutty Hill-Balto Co

MOTHER

14. Maiden Name Mary Smith

15 Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1 48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto

18 (a) Funeral director Orr & Harrison

(b) Address 3001 Pinkney ave

19 OCT 30 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 28 - 1948, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-25- 1940, to 10-27- 1948. and that I last saw him alive on 10-27- 1948.

Immediate cause of death	Duration
Pulmonary Oedema	24 hrs.
Due to Valvular Heart Disease	8 years
Due to Generalised arterio-sclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Melton C. Lacy M. D.

Address 2117 Belair Rd Date signed 10-28-48

VS 150

668125

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

74a

Registered No. 668125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 N. Arison
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Bkpg
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1534 Eutaw (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Brent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Negro

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1888.

8. AGE: Years 60 | Months — | Days — | If less than one day hr. min.

9. Birthplace Fayetteville, N.C. (Town, county, and state)

10. Usual Occupation Ice Dealer.

11. Industry or business

FATHER
12. Name
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Jones
15. Birthplace N.C.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 30 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion.
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St

19 (a) Oct. 28 1948 (b) Filed by Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27- 1948, at 2 [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27- 1948, to 10-27- 1948, and that I last saw him alive on 10-27- 19

Immediate cause of death, Uremia — Duration

Due to Interstitial nephritis

Due to

Other Conditions 2nd lung pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Provident Hosp Date signed 10-27-48

VS 190

68126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

926 Registered No. 68126

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17-07
(c) Hospital or institution: Hosp Women Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 64
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 Miles Ave -
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

3 (a) FULL NAME Lillie May Snouffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife John A Snouffer
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Jan - 17 - 1907

8. AGE: Years	Months	Days	If less than one day
41	9	10	..... hr. ..... min.

9. Birthplace Baltimore - md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Haberle
13. Birthplace Baltimore

MOTHER
14. Maiden Name Minnie Cooper
15. Birthplace Baltimore

16 (a) Informant Lillie M. Snouffer
(b) Address 2827 Miles Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30/1948 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Hampden.

18 (a) Funeral director Chas L E Lehmanowsky Jr.
(b) Address 3615-17 Chestnut Ave

19 OCT 30 1948 (Date rec'd by registrar) (b) Washington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 27 1948 at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct - 25 1948 to Oct 27 1948 and that I last saw her alive on Oct 27 1948

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Mitral Stenosis	
Due to Rheumatic Heart Disease	15 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: Mitral stenosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature George K Leatherman M. D.
Address Hosp. Wom. Md. Date signed X - 27 - 48

VS 190

68127

ES-52529

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a ✓ Registered No. 68127

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS 18 0
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 853 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Michel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? 1883

8. AGE: Years	Months	Days	If less than one day
65?	-	-	hr. min.

9. Birthplace Maine (Town, county, and state)
10. Usual Occupation Sells Pencils
11. Industry or business

FATHER
12. Name Peter Michel (D)
13. Birthplace Newfoundland

MOTHER
14. Maiden Name Mary ? (D)
15. Birthplace ?

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 1 1948 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary Cem
Location Balto. County

18 (a) Funeral director John M. Weber
(b) Address 48 S. Chester Street

OCT 30 1948 (b) Baltimore, Md. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13 1948 at 7:15 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 2-2- 1940 to 10-13 1948, and that I last saw him alive on 10-13 1948

Immediate cause of death	Duration
Coronary Thrombosis	1 hr.
Due to Coronary Sclerosis	2-3 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Stutzman M. D.
Address Balto. City Hosp. Date signed 10-29-48

X

G68128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G68128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3530 Greenmount Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life--.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3530 Greenmount Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry S. Marshall

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Margaret Marshall nee Bechtol

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1867

8. AGE: Years 80 | Months 11 | Days 9 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Sail maker

11. Industry or business Al. Roberts Co.

FATHER
12. Name Robert Marshall
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Jones
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Wm. H. Davis
(b) Address 3530 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 30 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 19[illegible] at 4 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 19 47 to Oct 25 19 48.
and that I last saw h[illegible] alive on Oct 2, 1947

Immediate cause of death: Coronary thrombosis — Duration 5 days

Due to: Coronary sclerosis

Due to: Chronic arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Bowden

Address 1517 E. North Ave. Date signed 10/27/48 M. D.

VS 150

H. A. Bowden

G68:29

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

✓ G68:29 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
Maryland General Hospital 17-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Myrtle Avenue (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME George Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Unknown

6 (b) Name of husband or wife ---------

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 75 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant: "
(b) Address "

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn, Maryland

18 (a) Funeral director Ralph L. Alles
(b) Address 600 McCulloh St.

19 OCT 30 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 30

20. DATE OF DEATH October 26, 1948, at 8 A. M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry find that said deceased came to his death on the day stated above, and death in my opinion resulted from: ~~natural causes~~, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A. S. C. V. D.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?
(d) Means of injury .....

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed 10-26-48

VS 151

68130 BC-C68404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 Pennsylvania Avenue
(c) Hospital or institution: 17-0

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Pennsylvania Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUSTACE NATHANIEL HERRINGTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1946

8. AGE: Years	Months	Days	If less than one day
1	10	28	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Leo Herrington
13. Birthplace South Carolina

MOTHER
14. Maiden Name Beatrice Weldon
15. Birthplace Washington D.C.

16 (a) Informant Leo Herrington
(b) Address 1214 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-48 (month, day, year)

(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) OCT 30 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1948, at 7.55 a.m.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/26/48

VS 151

68131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No. 68131

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & 33rd Streets

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks

(e) Length of stay in Baltimore (yrs., mos., or days) 3 wks

2. USUAL RESIDENCE OF DECEASED:

(a) State Kentucky (b) County —

(c) City or town Henderson (If outside city or town limits, write RURAL and name town)

(d) Street No. 234 South Main St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Mr. James J. Wiseman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs. Alene Wiseman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-27-1895

8. AGE: Years	Months	Days	If less than one day
52	0	3	hr. min.

9. Birthplace KENTUCKY (Town, county, and state)

10. Usual Occupation Oil Field Worker

11. Industry or business

FATHER 12. Name Mr W.M. Wiseman

13. Birthplace Kentucky

MOTHER 14. Maiden Name Mary Carroll

15. Birthplace Kentucky

16 (a) Informant wife

(b) Address 234 South Main St, Henderson

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)

(c) Cemetery or crematory Compton

Location Compton, Kentucky

18 (a) Funeral director Wm Cook Sons

(b) Address 621 St Paul St Huntington Williams, Mgr

19 (a) OCT 30 1948 (b) Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 19 48 at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 19 48 to Oct 30 19 48. and that I last saw h alive on Oct 30 19 48

Immediate cause of death Cardiorespiratory failure — Duration 5 days.

Due to Carcinoma of stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-16-48

Major findings of operation: Metastases on omentum

of autopsy Bx proved adenocarcinoma

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Eleanor P. Grove, M.D.

Address Union Memorial Hospital Date signed 10/30/48

VS 150

068132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 068132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1936 Brunt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1936 Brunt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hamilton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Separated

6 (b) Name of husband or wife Loretta Hamilton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 12, 1897

8. AGE: Years	Months	Days	If less than one day
51	3	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Produce Dealer.
11. Industry or business

FATHER
12. Name John Hamilton.
13. Birthplace Hot Spring W. Va.

MOTHER
14. Maiden Name Mary J. Hughes.
15. Birthplace Baltimore, Md.

16 (a) Informant Elmer Hamilton.
(b) Address 802 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location

18 (a) Funeral director Mrs Katye R. Williams
(b) Address 322 N Schroeder St (Huntington Williams Mgr)

19 (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1948 at 6 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1948 Oct 28 1948
and that I last saw h[illegible]e on 19

Immediate cause of death: Acute Broncho-pneumonia — Duration: [illegible]
Due to
Due to Bronchial Asthma one year
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Christopher Shelton M. D.
Address 200 S. Sharp St. Date signed 10/29/48

VS 150

AB-124113 168133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

013 K

Registered No. 168133

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days

(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 433 N. ~~Exeter~~ Exeter St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willard Sutton (Willard O. Sutton)

3 (b) If veteran, name war	3 (c) Social Security Account No.
?	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? ? ? June 25, 191

8. AGE: Years	Months	Days	If less than one day
33	4	4	hr. min.

9. Birthplace West Virginia (Harrison Co.)
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER

12. Name Nathen G. Sutton

13. Birthplace West Virginia

MOTHER

14. Maiden Name Una Kemper

15. Birthplace West Virginia

16 (a) Informant Records, Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/30/48 (month) (day) (year)

(c) Cemetery or crematory

Location Clarksburg, West Virginia

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.

(b) Address North & Pa. Aves. Balto. 17

19 (a) Filed by registrar Huntington Williams, M.D.

OCT 31 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29- 1948 at 9.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27- 1948 to 10-29- 1948 and that I last saw h in alive on 10-29- 1948

Immediate cause of death	Duration
(a) Far advanced Pulmonary tuberculosis	7 yr.
Due to	
(b) Tuberculosis of (st. lit) Malnutrition	8 yrs. 3 mos.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)

(e) Means of injury —

23. Signature Frank M. Shipley M.D.

Address Balto. City Hosp. Date signed 10-30-48

668:34 Court Case ✓ X 668:34

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 Randall Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DIXIE STERAGO

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Anthony Sterago
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1914

8. AGE: Years	Months	Days	If less than one day
33 33	10	24	hr. min.

9. Birthplace Black Creek, N.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Anthony John Sterago
(b) Address 103 W. Randall St-West Annapolis

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Contentnea
Location Wilson, N.C.

18 (a) Funeral director B. L. Hopping & Son
(b) Address Annapolis, Md.

19 (a) OCT 31 1948 (Date rec'd by Registrar) (b) Contentnea Wilson N.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, 1948, at 3:10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-28-48 at 3:30 P. M.
(b) Where did injury occur? 103 Randall St., Annap. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Firearms

23. Signature Earl Royle M.D. (Medical Examiner)
Date signed 10-30-48

VS 151

X

668135 ✓X 668135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Newark (If outside city or town limits, write RURAL and give town)
(d) Street No. 30 Academy St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH Lizzie Bell BELL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Samuel Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Rumania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name David Schwartz
13. Birthplace Rumania

MOTHER
14. Maiden Name Sarah Cohen
15. Birthplace Rumania

16 (a) Informant Beatrice Cohen
(b) Address 107 Botwood Rd. Wilmington, Del.

17 (a) (Burial, cremation, or removal) (b) Date thereof 10/31/48 (month) (day) (year)
(c) Cemetery or crematory Lombardy
Location Wilmington, Delaware

18 (a) Funeral director John O. Mitchell
(b) Address 1900 Eutaw Place.

OCT 31 1948 (Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Oct 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull & intra cranial bleeding

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-30-48 at 12 noon M.
(b) Where did injury occur? Tavern at 1534 Chalgrove Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury Lost balance and fell down flight of steps

23. Signature Earl Ruggles M.D. Medical Examiner.
Date signed 30 Oct 48

VS 151

G68136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68136

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 ROLAND AVE.
(c) Hospital or institution: KIRKLEIGH VILLA
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 YR.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 ROLAND AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME (Annie) ANNA E DEVON.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr) ----------

8. AGE: Years	Months	Days	If less than one day
About 76	--	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business --------

FATHER
12. Name William H. Devon
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Ella E. Roney
15. Birthplace Baltimore, Maryland

16 (a) Informant William Devon
(b) Address 6 E. Read Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert St.

19 (a) NOV 21 1948 (b) (Registered by Registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 29 1948 at 6.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 15 1947 to OCT 29 1948 and that I last saw [illegible] alive on OCT 28 1948.

Immediate cause of death	Duration
ACUTE CARDIAC DILITATION OCT	29.48
Due to HODGKINS DISEASE	AUG 47.
Due to CHRONIC ARTHRITIS	1948
Other Conditions	

(Include) [illegible] (Uncle) death)

Date of operation AUGUST 1947.
Major findings of operation: HODGKINS DISEASE LYMPH GLANDS OF THE THYROID GLAND
of autopsy NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. T. Williams M.D.
Address 3013 ST PAUL STREET Date signed OCTOBER 29 1948

BC- 48-3385 G68137 ✓ G68137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160 C Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4220 Berger Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Ronald Zobig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-22-48

8. AGE: Years | Months | Days 7 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Zobig
13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Kleiner
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Memorial (Park)
Location Washington Blvd.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

OCT 31 1948 (Date rec'd by registrar) (b) Registrar Washington Williams, M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1948, at 9205 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23-1948 to 10-29 1948, and that I last saw him alive on 10-29 1948.

Immediate cause of death	Duration
Meconium Ileus	8 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct 23, 1948

Major findings of operation: Meconium filled bowel

of autopsy: Peritoneal fluid, enlarged liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Handelsman M. D.
Address The Johns Hopkins Hospital Date signed 7

668138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

061

668138

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4217 Rayman Ave
(c) Hospital or institution: 4-04

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4217 Rayman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mollie Schillfarth

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fred J. Schillfarth

6 (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): March 14, 1901

8. AGE: Years 47 | Months 7 | Days 16 | If less than one day: hr. min.

9. Birthplace: Balto County - Md (Town, county, and state)

10. Usual Occupation: Nurse

11. Industry or business:

FATHER
12. Name: John Hoffman
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Muller
15. Birthplace: Germany

16 (a) Informant: Frederick J. Schillfarth
(b) Address: 4217 Rayman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/2/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Milton Ave + Rose St.

18 (a) Funeral director: Howard V. Blythe
(b) Address: 6009 Harford Road

19 (a) 1948 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 30 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1947, to Oct 30 1948 and that I last saw h[illegible] alive on Oct 4 1948.

Immediate cause of death	Duration
Diabetes	2 yrs
Hypertension	2 yrs
Due to Myocardial degeneration	3 mos
Due to [illegible]	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Edward Weis M. D.
Address: W. Ostend Date signed: 10/30/48

VS 150

668139

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH

170c

668139

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
St. Joseph's Hospital 10-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Balto.,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Summerset Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Bridge

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1908

8. AGE: Years 40 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(City or county and state)

10. Usual Occupation Stock clerk

11. Industry or business Sears Roebuck & Co.

FATHER
12. Name Henry F. Bridge
13. Birthplace Germany

MOTHER
14. Maiden Name Anna B. Zintgraf
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Anna B. Bridge
(b) Address 1021 Summerset Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director Elmer W. Conklin
(b) Address 924 E. Eager Street

19 (a) OCT 31 1948 (Date received by registrar) (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1948, at A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ✓, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull.
Due to Intracranial hemorrhage.
Due to Contusion of brain

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-24-48 at Approx. 4:40 P.M. 9/8
(b) Where did injury occur? Kirk Avenue, 36' south of 22nd Street
(c) Did injury occur at home, on farm, in industrial place, in public place? Public While at work? no
(d) Means of injury Ped. struck by truck

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/28/48

VS 15t

X

668140

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1174

Registered No. 668140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 Mura St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Mura St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur O. Link

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-01-0598

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary J. Connolly Link

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1881

8. AGE: Years 67 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md. (City, county, and state)

10. Usual Occupation Watchman

11. Industry or business Crown Cork & Seal Co

FATHER
12. Name George Link
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Kuna
15. Birthplace Germany

16 (a) Informant Mrs. Mary A. Link
(b) Address 715 Mura St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edgar W. Corkran
(b) Address 924 E. Eager St.

19 (a) Oct 31 1946 (date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1946, at 10:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Oct 29 1946. and that I last saw h[illegible] alive on Oct 29 1946.

Immediate cause of death: Pulmonary Edema — Duration: 17 hrs.

Due to Myocarditis, Chronic with decompensation — 3 years

Due to Duodenal Ulcer. — 3 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A. Donaghy M.D.

Address 10 E. Biddle St. Date signed 10/30/46

V S 190

Huntington Nativity, MD

68141 ✓ X 68141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 0136

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53-9-26

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis (If outside city or town limits, write RURAL and give town)
(d) Street No. unknown (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Sheehan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — 1876

8. AGE: Years	Months	Days	If less than one day
72	?	?	hr. min.

9. Birthplace St. Louis, Missouri (Town, county, and state)
10. Usual Occupation mental patient - 53 yrs.
11. Industry or business

FATHER
12. Name John Sheehan
13. Birthplace Ireland

MOTHER
14. Maiden Name Alice O'Keefe
15. Birthplace Ireland

16 (a) Informant The Seton Institute
(b) Address 6420 Reisterstown Rd., Balto 15, Md

17 (a) Burial (b) Date thereof 11-1-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Sherwood Memorial Co
(b) Address 08 W. Fayette
19 (a) Date filed by registrar OCT 31 1948 (b) Kensington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1948, at 11:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1930 to Oct. 29 1948, and that I last saw her alive on 10-29 1948.

Immediate cause of death Myocarditis — Duration 4 weeks
Due to
Due to
Other Conditions Fibroid Tuberculosis, Mental Deficiency
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Domenic P. Alagia M.D.
Address 33 W. Fayette St. Date signed

32

68142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68142

1. PLACE OF DEATH: Home for Incurables
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution:
Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-3-15
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander B. Gillespie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	

6 (b) Name of husband or wife Fanny P. R. Gillespie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1864

8. AGE: Years	Months	Days	If less than one day
84	8	24	hr. min.

9. Birthplace Londonderry, Ireland (Town, county, and state)
10. Usual Occupation Supt.
11. Industry or business Steamship

FATHER
12. Name William Gillespie
13. Birthplace Londonderry, Ireland

MOTHER
14. Maiden Name Eliza Hyndman
15. Birthplace Londonderry, Ireland

16 (a) Informant Jane L. Adamson, Supt.
(b) Address Home for Incurables

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1 1948 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave, City

19 (a) [illegible] (Signature of registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1948, at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1943 to 10/29 1948. and that I last saw him alive on 10/28 1948

Immediate cause of death: Spontaneous Pneumothorax

Due to: arteriosclerotic Cardio-

Due to: Vascular Renal Disease

Contributory Vascular Cerebral

Other Conditions: Paresis (Syph.)

Bilateral Inguinal Hernias

(Include pregnancy within 3 months of death)

Duration
30 Hours
10 years
6 years
20 years

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hersperger M. D.
Address 214 Medical Arts Building Date signed 10/29/48

VS 153

G68143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462

G68143 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2414 Crest Road
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) ~~Penna~~ Baltimore City
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2414 Crest Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE MARSH JAMES

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Blaine L. James
6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): August-11-1885

8. AGE: Years	Months	Days	If less than one day
63	2	18	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: None

FATHER
12. Name: Joshua Marsh
13. Birthplace: Baltimore Maryland

MOTHER
14. Maiden Name: Rebecca Albin
15. Birthplace: Baltimore Maryland

16 (a) Informant: Mrs. Ruth J. Wagner (daughter)
(b) Address: 2414 Crest Road, City #9

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-1-1948 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville, Maryland

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 W. North Avenue, City #1

19 (a) Filed OCT 31 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1948 at 3 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 1946 to Oct 29 1948 and that I last saw her alive on Oct 29 1948

Immediate cause of death	Duration
Carcinoma of Colon with Cerebral Metastases	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10/3/48
Major findings of operation: Carcinoma Sigmoid Colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Wallenstein M. D.
Address 898 W 36th St Date signed 10/29/48

VS 150

G68144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 186 M 68144

CERTIFICATION APPROVED BY

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LINDEN Ave. AND MADISON ST.
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 N. CALVERT ST (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME ELLA DEAN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	WW	WIDOWED

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
90	2	17	hr. min.

9. Birthplace PENNSYLVANIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name JEREMIAH FISCHER
13. Birthplace PENNA.

MOTHER
14. Maiden Name NANCY (UNKNOWN)
15. Birthplace PENNA.

16 (a) Informant H. CLAY DEAN (SON)
(b) Address 2510 N. CALVERT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory
Location Addison PENNA.

18 (a) Funeral director H. H. Williams and Son
(b) Address 805 N. Calvert St.

(a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1948, at 3:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1948, to 10/30 1948, and that I last saw her alive on 10/30 1948.

Immediate cause of death CORONARY THROMBOSIS — Duration

Due to ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

Due to

Other Conditions FRACTURE OF LEFT FEMUR (Include pregnancy within 3 months of death)

Date of operation 10/13

Major findings of operation: FRACT. OF LEFT FEMUR

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ACCIDENT 17-03
(b) Date of occurrence 10/6/48 at M
(c) Where did injury occur? BALTIMORE, MD. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME While at work? NO (Specify type of place)
(e) Means of injury FELL GETTING OUT OF BED

23. Signature Paul D. Arnold
Address Md. Gen. Hosp. Date signed 10/30/48 (M. D.)

VS 190

TO BE OKAYED BY MEDICAL EXAMINER

Please write the causes of death clearly and legibly.

668145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668145

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 141 S Collington Ave
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 141 S Collington Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary F Graber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-14-1889

8. AGE: Years 59 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John F Graber
13. Birthplace Md

MOTHER 14. Maiden Name Anna Sadtler
15. Birthplace Md

16 (a) Informant John F Graber
(b) Address 141 S Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Guy C A Hyde
(b) Address Catonsville Md

(a) Date rec'd by Registrar OCT 31 1948 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-26 1948 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May-31 1945 to Oct-25 1948, and that I last saw h[illegible] alive on May-25 1948.

Immediate cause of death: Hyaline Blood Pressure
Due to: Arterio Sclerosis
Due to: Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration: 4 yrs. / 3-4 yrs.

Date of operation No
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D Lloyd Johnson M. D.
Address Catonsville Md Date signed 10/30/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68146 BALTIMORE CITY HEALTH DEPARTMENT G68146
Registered No.

CERTIFICATE OF DEATH 94a

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2325 Pennsylvania
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 Penna. Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Joffe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years: 72 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Merchant

11. Industry or business:

FATHER
12. Name: Solman
13. Birthplace: Russia

MOTHER
14. Maiden Name: Not Known
15. Birthplace: Russia

16 (a) Informant: Ida Joffe
(b) Address: 2325 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-31-48 (month) (day) (year)
(c) Cemetery or crematory
Location: Hebrew Hevrah Linas

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2106 Eutaw Place

19 (a) Filed 1948 (b)
(Date rec'd by registrar) Registrar

Transcription for Baltimore, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30- 1948 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28 1948 to 10/29 1948 and that I last saw him alive on 10/29 1948

Immediate cause of death: Coronary occlusion

Due to: arteriosclerosis

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Daniel Wilson

Address 5771 Park Heights Ave Date signed 10/30/48

VS 153

68147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Portsmouth
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS BRUTUS Coker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: GRACE C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): NOV. 4 1884

8. AGE: Years 63 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace: NORTHHAMPTON VA.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: THOMAS B. COKER
13. Birthplace: NORTH CAROLINA

MOTHER
14. Maiden Name: ANNIE M. AQUIRES
15. Birthplace: VIRGINIA

16 (a) Informant: MRS. GRACE C, COKER
(b) Address: PORTSMOUTH VA.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof NOV. 2/48 (month) (day) (year)

(c) Cemetery or crematory: OAK GROVE
Location: PORTSMOUTH VA.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: NORTH & PENN. AVES.

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1948 at 1:35 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Hefner M.D.
Medical Examiner

Date signed Oct 30, 1948

VS 151

38148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

✓ 668148 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2007 Elsinor Ave
(c) Hospital or institution: 15 E 6
(d) Length of stay in Hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1yr 10 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Elsinor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miss Anna Start

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20 - 1875

8. AGE: Years 73 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Clerk

FATHER 12. Name John Wesley Start

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Hester Foreman

MOTHER 15. Birthplace Pa.

16 (a) Informant Mrs. Harrison (Mrs. Paulline)

(b) Address 2007 Elsinor Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11 / 1 / 48 (month) (day) (year)

(c) Cemetery or crematory Odd Fellows

Location Smyrna Delaware

18 (a) Funeral director D. Wells Faries

(b) Address Smyrna, Delaware

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1948, at 6 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1948 to Oct 31 1948 and that I last saw h[illegible] alive on Oct 31 1948.

Immediate cause of death Acute dilitation — Duration 2 hrs

Due to Myocarditis — Duration about 4 mo.

Due to arterio-sclerosis — Duration ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter S. Rubbatt, M. D.
Address 2220 Garrison Blvd Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

× Oct 31/48

G68149

ES-123274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G68149 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Montery Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Manie Murphy

3 (b) If veteran, name war: N

3 (c) Social Security Account No.: NONE

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 23, 1871

8. AGE: Years 77 | Months 0 | Days 8 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Conrad Razarenus (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Ottman (D)
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS.
(b) Address 4940 EASTERN AVE.B

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilhorn & Son
(b) Address 1217 E Fayette St

19 (a) NOV 1 1948 (b) Registrar
(Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31 1948 at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1948 to 10-31 1948 and that I last saw her alive on 10-31 1948

Immediate cause of death: Cerebrovascular Accident — Duration: 1 mon.

Due to

Due to

Other Conditions Hypertension, arteriosclerotic Heart disease — Duration: 5yrs +
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John E. Redstold M. D.
Address Balto City Hosp. Date signed 10-31-48

VS 150

83a

668150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 Aiken St.
(c) Hospital or institution: 9-08
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Aiken St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE BARNES BUCK

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Maxwell A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 20, 1871

8. AGE: Years	Months	Days	If less than one day
77	2	9	hr. min.

9. Birthplace Norwich, Conn (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William W. Barnes
13. Birthplace Norwich, Conn

MOTHER
14. Maiden Name Martha Williams
15 Birthplace Norwich, Conn

16 (a) Informant William B. Hall
(b) Address 7108 Chambers Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1930 to Oct 29 1948 and that I last saw h alive on Oct 29 1948.

Immediate cause of death Cerebral Hemorrhage — Duration 1 day
Due to Cardio Vascular Dz — 10 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fritz J Schnitzer M D
Address 2700 Harford Rd Date signed 10-30-48

68101 BC-F62480

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

010 ✓ 68101 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 Scott St (If rural give location)
(e) Citizen of foreign country? Yes or No ✓
If yes, name country

3 (a) FULL NAME DIANE PERRERA

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14 1942

8. AGE: Years	Months	Days	If less than one day
5	11	17	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Orlando Serra
13. Birthplace Conn.

MOTHER
14. Maiden name Hekimian
15. Birthplace Baltimore Md

16 (a) Informant Betty Serra
(b) Address 2626 Hampden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Wilson & Johnson
(b) Address 1317 Light St

19 NOV 1 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31, 1945 at 12:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31, 1945 to Oct 31, 1945 and that I last saw her alive on Oct 31, 1945

Immediate cause of death	Duration
Laryngeal Obstruction	
Due to Pharyngo-Laryngeal Diphtheria	
Due to	
Other Conditions none	

(Include pregnancy within 3 months of death)
Date of operation Tracheotomy Oct 31, 45
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allan J. Wolinsky M. D.
Address Sinai Hospital Date signed Oct 31, 45

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

Registered No. 668152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4353 Reisterstown Road
(c) Hospital or institution: 15 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4353 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dora Nee Kerpelman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan, 12, 1894

8. AGE: Years	Months	Days	If less than one day
54	9	19	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Ice Dealer

FATHER
12. Name Sidney Nelson
13. Birthplace Russia

MOTHER
14. Maiden Name Mary Monen
15 Birthplace Russia

16 (a) Informant Mrs. Dora Nelson
(b) Address 4353 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov, 1. 1948 (month) (day) (year)
(c) Cemetery or crematory Workmen Circle Cemetery
Location Hebrew Mt Carmel Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1948, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1948 to Oct 31, 1948, and that I last saw h alive on Oct 31, 1948.

Immediate cause of death Cerebral Tumor (Glioma) — Duration 6 mos

Due to

Due to

Other Conditions (include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Manuel Levin
Address 4818 Reisterstown Rd Date signed Oct 31/48 M. D.

VS 159

5668153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 668153

1. PLACE OF DEATH: Levindale Home
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4149 Fairview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA ESTHER ROSENZWEIG

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation
11. Industry or business: None

FATHER
12. Name: Abraham Freeman
13. Birthplace: Poland

MOTHER
14. Maiden Name: Diena ?
15. Birthplace: Poland

16 (a) Informant: Mrs Morris Grossfeld
(b) Address: 4149 Fairview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1, 1948 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedlae Cem
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 NOV 1 1948 (Date rec'd by registrar) (Signature of registrar) Wellington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31 1948 at 11:42 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1948 to 10-31 1948 and that I last saw her alive on 10-31 1948

Immediate cause of death	Generalized Arteriosclerosis	Duration
Due to	Diabetes mellitus	
Due to		
Other Conditions	Amputation right leg	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Home Date signed 10/31/48

VS 150

X

66814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. 66814

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 E. Lake Ave
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 E. Lake Ave
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Hollstein Jory

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Herbert G. Jory

6 (c) If alive, give age ~~Years~~

7. Birth date of deceased (mo., day, yr.) June 7, 1879

8. AGE: Years	Months	Days	If less than one day
69	4	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John C. Hollstein
13. Birthplace Germany

MOTHER
14. Maiden Name Rose Harman
15. Birthplace Maryland

16 (a) Informant Mr. John G. Jory
(b) Address 3305 Staunton Ave., Charleston, W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Arlington National
Location Arlington, Va.

18 (a) Funeral director Edward O. Mitchell & Sons
(b) Address 1900 Eutaw Place, Baltimore, Md.

19 (a) Nov 1 1948 (Date received by Registrar) (b) [illegible] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1948 at 11:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1947 to October 27 1948, and that I last saw her alive on October 27 1948.

Immediate cause of death	Duration
Acute pulmonary edema	½ hour
Due to Arteriosclerotic cardiovascular disease	20 yrs
Due to	
Other Conditions Arterial Hypertension (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frederick J. Vollmer M. D.
Address 6100 York Road Date signed 10-27-48

668155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

668156 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104
(c) Hospital or institution:
The Hospital for the Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47
(e) Length of stay in Baltimore (yrs., mos., or days) 80 ? [redacted]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hampton Court Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Pennington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Noble Pennington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1864

8. AGE: Years	Months	Days	If less than one day
84	6	16	hr. min.

9. Birthplace Towson, Md.
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Joseph J Stewart
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Baynes
15. Birthplace

16 (a) Informant Mrs. Clifford E. Waller
(b) Address 1707 Highland Drive Silver Spring Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) NOV 1 [redacted] (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1948 at 11:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1948 to Oct. 29 1948 and that I last saw her alive on Oct. 29 1948.

	Duration
Immediate cause of death Generalized Carcinomatosis	
Due to Metastases from old Breast Cancer	6 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Consultant Louis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Chesley Decker M. D.
Address Woman's Hospital Date signed 10-29-48

VS 180

Physicians: please write the causes of death clearly and legibly. Cause 1(a) is especially important.

668146 X ✓ G668156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 469

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 WINDSOR AVE.
(c) Hospital or institution:
WINDSOR REST HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5wks
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town WOODLAWN (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 KERNAN DRIVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE M. SHIPLEY

3 (b) If veteran, name war

3 (c) Social Security Account No. ***

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MLE	W HITE	MARRIED

6 (b) Name of husband or wife DORA A. SHIPLEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 - 14 - 1892

8. AGE: Years	Months	Days	If less than one day
56	5	15	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Mrs. Ethel Miller

FATHER
12. Name William Shipley
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Martin
15. Birthplace Maryland

16 (a) Informant Mrs. Dora A. Shipley
(b) Address 1908 Kernan Drive, Woodlawn

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory WESTERN CEMETERY
Location BALTIMORE MARYLAND

18 (a) Funeral director F. B. KIPPERT & SON
(b) Address 1300 EUTAW PLACE..17

19 (a) 3 1948 (Date rec'd by Registrar) (b) Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 29, 1948 19 at 10:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1948 to Oct 29 19 48 and that I last saw h 1 alive on Oct 28 19 48

Immediate cause of death	Duration
General carcinomatosis (Metastasis)	3 mos
Due to Carcinoma of pancreas	6 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation April-48
Major findings of operation: Carcinoma of pancreas - secondaries
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I Frederick Lantz M. D.
Address Temple Sinai Date signed Oct 29 48

VS 150

66817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. 66817

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N. Schroeder St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-5155

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7-15-07

8. AGE: Years	Months	Days	If less than one day
41	3	15	hr. min.

9. Birthplace NC (Town, county, and state)

10. Usual Occupation Long Shoreman

11. Industry or business

FATHER
12. Name Henry Lewis
13. Birthplace NC

MOTHER
14. Maiden Name Sarah Page
15. Birthplace NC

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory Mulberry Branch
Location Burgaw, N.C.

18 (a) Funeral director Charles C. Cooper
(b) Address 512 N. Carrollton Ave

NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1948, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7-1948 to 10-30 1948 and that I last saw him alive on 10-30 1948

Immediate cause of death: Respiratory Failure — Duration: 3 min.

Due to meningitis

Due to Miliary Tuberculosis

Other Conditions Tbc. Peritonitis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Miliary Tuberculosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan Calkins

Address J H Hosp Date signed 10/30/48 (M.D.)

VS 150

68158

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61 ✓

Registered No. 68158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 141 N Dennison St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 141 N. Dennison St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Lee Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	widowed

6 (b) Name of husband or wife Nate Geo. born

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1887

8. AGE: Years	Months	Days	If less than one day
61	5	27	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Hood
13. Birthplace Md

MOTHER
14. Maiden Name Susan
15. Birthplace Md

16 (a) Informant Charles Johnson (son)
(b) Address 141 N. Dennison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Co. Md.

18 (a) Funeral director Harry A. Whitzel
(b) Address 4101 Edmondson Ave

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1948, at 11 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1948 to Oct 30 1948, and that I last saw h[illegible] alive on Oct 30 1948

Duration
Immediate cause of death: acute cardiac failure — 1 day
Due to: asteno sclerotic cardio-vascular renal disease — 1 yr
Due to: diabetes mellitus — 7.
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A Krupp M.D.
Address 3030 Edmondson Ave Date signed 10/30/48

VS 150

131a

6681:59

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

Registered No. 6681:59

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital ~~[illegible]~~ St. Joseph's 27-05
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6706 Everall (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

2 (a) FULL NAME Mr. Louis Henry Simokat

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	— —

6 (b) Name of husband or wife Helena Ursula
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1878

8. AGE: Years	Months	Days	If less than one day
70	6	21	hr. min.

9. Birthplace East Prussia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry Simokat
13. Birthplace Germany

MOTHER
14. Maiden Name Schaeffer
15. Birthplace Germany

16 (a) Informant Mrs. John J. Brown
(b) Address 6706 Everall ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1/48 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial
Location Taylor ave.

18 (a) Funeral director Harry H. Nitsche
(b) Address 4181 Edmondson ave.

19 NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH October 28, 1948, at 9:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15, 1948 to Oct. 28, 1948, and that I last saw h im alive on Oct. 28, 1948.

Immediate cause of death	Duration
Acute myocardial insufficiency	
Due to Arterio sclerotic Heart Disease	
Due to	
Other Conditions Bronchogenic Carcinoma (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
23. Signature Ray E. Brown Jr. M.D. (M. D.)
Address 1 S. Paca St. Date signed 10/28/48

VS 139

93d

G68160 died 10/29/48 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74A Registered No. 68160

Med Exam Case

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2633 Maisel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bruce L. Benny

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 3 | Months 7 | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Benny
13. Birthplace

MOTHER 14. Maiden Name Sarah Wilhide
15. Birthplace

16 (a) Informant G. Sherwood Benny
(b) Address 2633 Maisel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 1 48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Harsen, Md

18 (a) Funeral director Harry H. Mitzel
(b) Address 4101 Eastern Ave

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29- 1948 at 4:00 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from June 12 1948 to Oct 29 1948, and that I last saw him alive on Oct 27 1948.

Immediate cause of death: Leukemia, aleukemic — Duration: 5 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

CERTIFICATION APPROVED BY
Thomas J. Mullen, M.D.
Wm L Hesford M.D.
CHIEF OR ASST. MEDICAL EXAMINER

Date of operation

Major findings of operation:

of autopsy: Leukemia

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Wollenweber M. D.
Address 101 W Read St Date signed Oct 30 48

68431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68103

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 831 N. Fulton Ave
(c) Hospital or institution: 16-03.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 831 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur E. Dunkley

3 (b) If veteran, name war

3 (c) Social Security Account No. 090-05-4615

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1-1894

8. AGE: Years	Months	Days	If less than one day
51	1	29	hr. min.

9. Birthplace Kingston Jamaica B.W.I.
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name John Dunkley
13. Birthplace B.W.I.

MOTHER
14. Maiden Name Jane Forbes
15. Birthplace B.W.I.

16 (a) Informant Lillian Maria Allegre
(b) Address 1729 Amsterdam Ave N.Y.C.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 11-2-48 (month) (day) (year)

(c) Cemetery or crematory Western Star
Location Catonsville

18 (a) Funeral director Samuel W. Sullivan Jr
(b) Address 1011 W. Arlington Ave

19 NOV 1 1948 (Date rec'd by registrar) (b) Evington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1948, at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May-10 1948, to Oct 30 1948, and that I last saw h[illegible] alive on Oct 30 1948.

Immediate cause of death	Duration
Chronic Endocrine Dis	
Due to Pulmonary Embolism	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 11/1/48

V S 150

68162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 ✓ (C) G68162 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 310 N. Stricker
(c) Hospital or institution: 19-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Stricker
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Cook

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-2637

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Grace W. Cook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10-1877

8. AGE: Years	Months	Days	If less than one day
71	-	19	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Laboratory Man
11. Industry or business Bosman Gunn Medicine Co.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Grace W. Cook
(b) Address 310 N. Stricker St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 11-1-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Lot

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1011 N. Arlington Ave.

19 NOV 1 1948 (Date rec'd by registrar) (b) Registrar for Williams Mills

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1948 at 6.10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/26 1948 to 10/29 1948, and that I last saw h-- alive on 10/14 1948.

Immediate cause of death Myocardial failure

Due to Hypertensive Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 yrs.
6 mos.
3 dys.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Preston Hurst M. D.
Address 6101 N. Carroll St. Date signed 10/30/48

V S 190

G68163

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

Registered No. G68163

1. PLACE OF DEATH:
(a) Baltimore City, Maryland (2403)
(b) Street address 2408 Maryland Ave
(c) Hospital or institution: none 11-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Linden Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Stanley Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1880

8. AGE: Years 68 | Months 7 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Amos J. Davis
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mamie High
15. Birthplace ?

16 (a) Informant: Mr. Elmer C. Smith
(b) Address 2 E. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Greenmount
Location Greenmount Ave. at Oliver St.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place, Baltimore

NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1948 at 8:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to ~~sudden~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D.
Medical Examiner.
Date signed 10-31-48

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No. 68164

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1226 Hanover St
(c) Hospital or institution: — 43 1

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) About 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Annie B. Amelung

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Herman J. Amelung
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) August 4, 1867

8. AGE: Years	Months	Days	If less than one day
81	2	26	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation at Home
11. Industry or business —

FATHER
12. Name ? Mueller
13. Birthplace Germany

MOTHER
14. Maiden Name ? ?
15. Birthplace Germany

16 (a) Informant: Mrs. Mary E. Woolford
(b) Address 226 Hanover St, Balto. Md. (Daughter)

17 (a) Burial — (b) Date thereof Tues, Mar. 2, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Balto Md

18 (a) Funeral director A. Howard Evans
(b) Address 1400 E. Charles St.

NOV 1 1948 (b) Lexington Williamsport Md
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sat. Oct 30 1948 at 9:55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1948 to 10/30 1948 and that I last saw her alive on 10/30, 1948.

Immediate cause of death: Cerebral hemorrhage — Duration 8 days

Due to —

Due to —

Other Conditions Hypertension
Cardio Vascular disease
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Harry Deibel M. D.
Address 1226 Hanover St Date signed 11/1/48

VS 150

83a

668165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

X ✓ 668165 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 Bishop Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Catherine Buschmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July - 1883

8. AGE: Years 65 Months 3 Days If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Secke (dec.)
13. Birthplace Md.

MOTHER 14. Maiden Name Anna (dec.)
15. Birthplace Md.

16 (a) Informant John Buschmann
(b) Address 15 Bishop Lane Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 2 1948 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Frederick Avenue

18 (a) Funeral director Edward J. Mauth
(b) Address Catonsville, Md.

19 (a) NOV 1 1948 (Date received by registrar) (b) Huntington-Williams, M.E.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1948 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26 1948 to 10-29 1948 and that I last saw h alive on 10-29 1948

Immediate cause of death Ca of Pancreas
Due to Chemical peritonitis

Duration 3 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pancreatitis Peritonitis Fatty Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Tansey M. D.
Address St Agnes Hosp Date signed 10/29/48

68166

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a ✓

G68166
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2201 Essex St.
(c) Hospital or institution: 1-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2201 Essex St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John. W. Lenz.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Male	White	Married

6 (b) Name of husband or wife Josephine Lenz
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr) July 23. 1891

8. AGE: Years	Months	Days	If less than one day
43.	3.	7.	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Carpenter P.R. Railroad
11. Industry or business

FATHER
12. Name Charles. P. Lenz
13. Birthplace Baltimore County

MOTHER
14. Maiden Name Catherine Heller
15. Birthplace Germany

16 (a) Informant Josephine. Lenz
(b) Address 2204. Essex. St.

17 (a) Burial. (b) Date thereof 11/1/1948.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak. Lawn.
Location Eastern ave.

18 (a) Funeral director Kendall J. Hoppel
(b) Address 312. S. Highland ave

19 (a) NOV 1 1948 (b) Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30/ 1948 at 3:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10/ 1948 to 10/28 1948.
and that I last saw h[illegible] alive on 10/27/1948

Immediate cause of death Coronary Sclerosis — Duration 2 wks

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Dr Father F. Hammond M. D.
Address 1165 East Ave Date signed

VS 150

Michael F. Kinkowski 10/30/48

68107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1-4a

Registered No. 68107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hosp. S-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 N. Eutaw
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Crosby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, ~~married~~, ~~widowed~~, or divorced.

6 (b) Name of husband or wife Margarite Crosby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 31, 1896

8. AGE: Years 52 | Months 3 | Days 0 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Warren Crosby
13. Birthplace Maryland

MOTHER
14. Maiden Name Ruby Smith
15. Birthplace Maryland

16 (a) Informant Partner or relative
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3060 E. Balt. St

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 31 1948 at 5:57 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1948 to 10/31 1948 and that I last saw him alive on 10/31 1948

Immediate cause of death	Duration
Cerebral embolism - air probably	
Due to Emphysematous bleb ruptured into dilated vessel in lung	
Due to Bronchiectasis - left	
Other Conditions Chronic alcoholism c early cirrhosis	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Massive air embolism of brain

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry V. Chase M.D.
Address Mercy Hospital Date signed 10/31/48

100 by

VS 150

8108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 469

Registered No. 668108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22nd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs. mos.~~ or days) 35
(e) Length of stay in Baltimore (~~yrs. mos. or~~ days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Rocks (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Daniel JONES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-21-06

8. AGE: Years	Months	Days	If less than one day
42	6	10	hr. min.

9. Birthplace Harford Co. Md. (Town, county, and state)
10. Usual Occupation Carpenters Helper
11. Industry or business

FATHER
12. Name Robert Albert Jones
13. Birthplace Harford Co. Md

MOTHER
14. Maiden Name Florence Curry
15. Birthplace Harford Co. Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4-48 (month) (day) (year)
(c) Cemetery or crematory Slate Ridge
Location Delta Pa.

18 (a) Funeral director Herbert S. Warburton
(b) Address Delta Pa.

19 (a) NOV 1 1948 (Date rec'd by registrar) Huntingtor Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 October 1948 at 9.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Sept 1948 to 31 Oct 1948 and that I last saw him alive on 31 Oct 1948

Immediate cause of death: Cardio-respiratory failure — Duration

Due to Carcinoma Pancreas & metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: Metastases

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature James McC. Finney M. D.
Address Union Memorial Hospital Date signed 10-31-48

VS 150

8169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940 ✓

Registered No. 668169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1432 N. Patterson Pk. Ave
(c) Hospital or institution:
§ C4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 N. Patterson Pk Ave (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME George C. Butera

3 (b) If veteran, name war: World War 2
3 (c) Social Security Account No. 220-07-0374
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed or divorced: Married
6 (b) Name of husband or wife: Rose M. Butera
6 (c) If alive, give age 24 years
7. Birth date of deceased (mo., day, yr.) July 24 1921
8. AGE: Years 27 Months 3 Days 5 If less than one day: hr. min.
9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Chauffeur
11. Industry or business: U. S. Gov.

FATHER
12. Name: Frank Butera
13. Birthplace: Italy

MOTHER
14. Maiden Name: Angela Marino
15. Birthplace: Italy

16 (a) Informant: Rose M. Butera
(b) Address: 1432 N. Patterson Pk. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Road

18 (a) Funeral director: John C. Milby Sons
(b) Address: 2405 E. Oliver St
(b) Huntington Williamsport Md

19 NOV 1 1948 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29-1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 to Oct 1948.
and that I last saw him alive on Oct. 25 1948.

Immediate cause of death: Coronary Thrombosis
Due to: polycythemia vera
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: two

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury
23. Signature Edward Novak M. D.
Address 101 W. Read St Date signed 10-29-48

VS 150

668170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932

Registered No. 668170

Please write the words or death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 S. Ann St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 412 S. Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maria Kowalczyk

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frank Kowalczyk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
89			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House work
11. Industry or business At home

FATHER
12. Name Casimir Maluszyk
13. Birthplace Poland

MOTHER
14. Maiden Name A. Gajewski
15. Birthplace Poland

16 (a) Informant Kasimira Kowalczyk
(b) Address 412 S. Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave.

NOV 1 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1948, at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1945 to Oct. 30 1948 and that I last saw h Er alive on Oct. 30 1948

Immediate cause of death: Coronary Occlusion — Duration 10/30/48

Due to: Hypertensive Arteriosclerotic — 12/27/45

Due to: Cardio-Vascular Dis.

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J. F. Drenga, M. D.
Address 2098 Chester St Date signed 11/1/48

VS 150

G68171

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

G68171 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 S Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 S Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Szulkowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Theodore Szulkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Adamski
15. Birthplace Poland

16 (a) Informant Bernice Chmielewski
(b) Address 222 S Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave Huntington Williams, Md.

19 NOV 1 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1948 to Oct 28 1948, and that I last saw h alive on 19

Immediate cause of death	Duration (Interval)
Pulmonary Tuberculosis	1 Mo
Due to Pulmonary Tuberculosis	1 Yr
Due to	
Other Conditions Arteriosclerosis	2 Yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed

VS 150

G68172

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47 C

G68172 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 320 S Durham St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 320 S. Durham St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph A Gable

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Agnes Gable
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 10 1902

8. AGE: Years	Months	Days	If less than one day
46		18	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name No Record
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 2 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave

19 NOV 1 1948 Huntingtown Calvert Co, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1948, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1947 to Oct 28 1948 and that I last saw h[illegible] alive on Oct 28 1948.

Immediate cause of death
Conclusion of Lost Bronchus
Due to Metastasis To Right Lung, Left Clavicle
Due to Mental, Emotional Stress Factors
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation December 1947
Major findings of operation: Carcinoma Inoperable
of autopsy:

Duration
One year

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F Faltick M. D.
Address 2 West Read Date signed Oct 28 48
Balto

VS 150

G68173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G68173 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 827 W. Franklin St.
(c) Hospital or institution: 17-02
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 827 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Alice Gurley, (Gerley) (Gary)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Widowed

6 (b) Name of husband or wife Joseph Gary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-21-82

8. AGE: Years	Months	Days	If less than one day
66	6	9	hr. min.

9. Birthplace Elkton, Maryland (Cecil) (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Armetta Jenkins
15. Birthplace Maryland

16 (a) Informant Louis C. Brown
(b) Address 827 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore, Maryland

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) NOV 1 1948 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1948, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10, 1948, to Oct 30 1948 and that I last saw h[illegible] alive on Oct. 30 1948.

Immediate cause of death — Duration
Cardio-Vascular Accident — 1
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed Nov 2 48

68174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 133 N Registered No. 68174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raymon and Dukeland
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Baker St #16
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J. Carmine

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-2735

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Elva Carmine
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr) Dec. 6, 1908

8. AGE: Years	Months	Days	If less than one day
39	10	25	hr. min.

9. Birthplace Baltimore. MD.
(Town, county, and state)
10. Usual Occupation Tool maker
11. Industry or business Glenn L. Martin Co

FATHER
12. Name EARL J. CARMINE
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name ELEANORA NEAL
15. Birthplace BALTIMORE MD.

16 (a) Informant MRS. ELVA E. CARMINE
(b) Address 3018 BAKER ST.

17 (a) BURIAL (b) Date thereof 11-3-1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LORRAINE PARK
Location WOODLAWN - MD

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave

19 (a) NOV 1 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31 1948, at 5:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1948 to 10/31 1948.
and that I last saw him alive on 10/31 1948.

Immediate cause of death Uremia

Due to Polycystic kidneys

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Confirmatory

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. B. Hooper M.D.
Address J. W. B. Hooper Hospital Date signed 10/31

VS 193

68175 Blum

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

516 Registered No. G68175

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3961 Willsby Avenue
(c) Hospital or institution:
9 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3961 Willsby Avenue
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Gabriel J. Rhein

3 (b) If veteran, name war [redacted] (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Anna M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 17, 1870

8. AGE: Years	Months	Days	If less than one day
78	2	11	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Rhein
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Thierolf
15. Birthplace Germany

16 (a) Informant Mrs. Henry J. Butt
(b) Address 3961 Willsby Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (Date rec'd by registrar) NOV 1 1948 Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28th 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1948 to Oct 28 1948 and that I last saw h/xx alive on Oct 28 1948.

Immediate cause of death Carcinoma of Prostate Gland — Duration 6 mos.
Due to
Due to
Other Conditions Arteriosclerotic Cardio-Vascular Renal Disease — 7
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Dr. Geo. S. Blum
Address 1115 N. Calvert St. Date signed 10/30/48 (M) (D)

VS 150

68176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Glendale (If outside city or town limits, write RURAL and give town)
(d) Street No. 8312 Beach Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gladys Madeline (Madge) Jester (Gladys Madeline (Madge) Jester)
3 (b) If veteran, name war
3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Oct 1948 at 11:53 A M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George C. Jester
6 (c) If alive, give age 40 years
7. Birth date of deceased (mo., day, yr.) March 21, 1903

8. AGE: Years	Months	Days	If less than one day
45	7	9	hr. min.

9. Birthplace New Market, Tennessee (Town, county, and state)
10. Usual Occupation School-teacher
11. Industry or business Baltimore County, Md.

FATHER
12. Name Henry Dario Pollard
13. Birthplace Tennessee

MOTHER
14. Maiden Name Martha Elizabeth Hatcher
15. Birthplace Tennessee

16 (a) Informant George C. Jester
(b) Address 8312 Beach Drive Glendale Md.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11-1-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Balto. Md.

18 (a) Funeral director E. Willis Lamoreau
(b) Address 1003 W. Baltimore St.

19 (a) Huntington Williams M.D. Registrar
(Date rec'd by Registrar) NOV 1 1948

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage,
Spontaneous
Due to Hypertension and P.V.D.
Other Conditions Fract. of Skull
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Beyer M.D. Medical Examiner.
Date signed 30 Oct 48

VS 151

G68177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186

Registered No. G68177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Scott Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: LENA (MANNER) MARTZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Theodore C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1876

8. AGE: Years	Months	Days	If less than one day
72	5	18	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business home

FATHER
12. Name Paul Manner
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Annie Wagoner
(b) Address 1151 W. Cross Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-48 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Longwood & Edmondson Avenue

18 (a) Funeral director JOHN J. COWAN & SON
(b) Address 1101-03 Hollins Street

19 (a) NOV 1 (Date rec'd by registrar) (b) Huntington Matanuska, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1948, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of left femur
Arteriosclerotic cardiovascular disease -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-25-48 at ? M.
(b) Where did injury occur? Court House
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No (outside)
(d) Means of injury Slipped and fell down steps

23. Signature [illegible] G. Merrill M.D. Medical Examiner.
Date signed 11/1/48

G68178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68178 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 W. Baltimore ST
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County —
(c) City or town Piedmont
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 52 W. Harrison ST
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Isabella Stanley

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Mr. Forrest Stanley

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Dec. 20, 1877

8. AGE: Years	Months	Days	If less than one day
70	10	11	— hr. — min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name John Jacob Ogden
13. Birthplace West Virginia

MOTHER
14. Maiden Name Sarah L. Watson
15. Birthplace West Virginia

16 (a) Informant Mrs. M. Griffin
(b) Address Church Home and Hospital

17 (a) Removal (b) Date thereof 11/1/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Piedmont West Va.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Eleanor St - 31 -

19 (a) NOV 1 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1948, at 11:38 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1948 to 10/31 1948. and that I last saw her alive on 10/26 1948

Immediate cause of death Cardiac failure
Respiratory paralysis
Myasthenia Gravis
Due to Generalized arteriosclerosis
Due to —
Other Conditions Fecal impaction

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. W. Mintzer
Address Church Home Date signed 11/1/48

VS 150

97

668179

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 668179

120a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 12 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: MAE MORGAN (COLLINS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1909

8. AGE: Years 38 | Months 11 | Days 19 | If less than one day hr min.

9. Birthplace: Columbia, N.C. (Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: Zion Midgett
13. Birthplace: Columbia, N.C.

MOTHER
14. Maiden Name: Mary E. Askew
15. Birthplace: Columbia, N.C.

16 (a) Informant: Mrs. Caddie Nelson (sister)
(b) Address: 2434 N. 15th St. Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3-48 (month) (day) (year)
(c) Cemetery or crematory
Location: Norfolk, Va.

18 (a) Funeral director: Elroy O. Wilson
(b) Address: 1000 Braniter ave

19 (a) NOV 1 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1948 at 4:30A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute gastro enteritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Ed. M. Roy M.D. Medical Examiner.
Date signed 10/29/48

VS 151

68180

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93 D

Registered No. 68180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Colvin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hattie HATTIE Leak LEAK

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	colored	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1894

8. AGE: Years	Months	Days	If less than one day
53		19	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Jack McEachin
(b) Address 246 Colvin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy B. Wilson
(b) Address 1000 Edmondson ave

19 (a) [illegible] (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, 1948, at 2.30 PM

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. Medical Examiner
Date signed 10-31-48

VS 151

668181 Liedtke ✓ 668181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Gilm & Lombard

(c) Hospital or institution: Mem. Hosp. ??

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 2917 Reuckert Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs Lillian Fredtke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed or divorced W

6 (b) Name of husband or wife Frederick L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14-1906

8. AGE: Years 41 Months 11 Days 17 If less than one day hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Dr. Frederick Humberg

13. Birthplace N.Y.

MOTHER 14. Maiden Name Lily A. Halberstadt

15. Birthplace England

16 (a) Informant Mr Fred. Humberg

(b) Address 2917 Reuckert Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-3-48 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto Co. Rock Raiford Rd

18 (a) Funeral director S[illegible]

(b) Address [illegible]

19 (a) NOV 1 (Date rec'd by registrar) (b) [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31 1948, at ?? M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1948 to 10-31 1948, and that I last saw h[illegible] alive on 10-31 1948.

Immediate cause of death Metastatic carcinoma

Due to Lung

Due to a & breast.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Date of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Howard E. Hull M.D.

Address 10-31 Lex. Pk. Date signed 11-6

VS 153

668182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3 a

668182 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824 S. Clinton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 S. Clinton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSA ROTH

3 (b) If veteran, name war	3 (c) Social Security Account No.
-----	-----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph Roth
6 (c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) May 15, 1867.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
81	5	16		

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business House Work

FATHER
12. Name John Doetzer
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Meyer
15. Birthplace Germany

16 (a) Informant Joseph Roth
(b) Address 824 S. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-48. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cemetery
Location German Hill Rd.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 901 S. Conkling St.

19 (a) NOV 1 1948 (b) (Rec'd by registrar) Huntington Millwood, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 48 10:30A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 25 1948 to Oct 31 1948 and that I last saw h alive on Oct 31 1948.

Immediate cause of death: Cerebral Hemorrhage
Arteriosclerosis
Due to Senility

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Duration: Oct 31 48

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. J. Ball M. D.
Address 3426 Bank St Date signed 11-1-48
3426 Bank St

G68183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G68183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 Winston Ave
(c) Hospital or institution: 27-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Winston Ave
(If rural, give location)
(e) Citizen of foreign country? [redacted] No (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Elizabeth Tischinger

3 (b) If veteran, name war: X

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife: August Robert Tischinger
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1890

8. AGE: Years	Months	Days	If less than one day
58	1	3	hr. min.

9. Birthplace: Harford Co., Md. (Magnolia)
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Thomas Stallman
13. Birthplace: Harford Co., Md.

MOTHER
14. Maiden Name: Frances V. Baldwin
15. Birthplace: Harford Co., Md.

16 (a) Informant: Mr. Roland Tischinger
(b) Address: 421 Winston Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory: Govans Presby. Cem.
Location: Govans, Balto., Md.

18 (a) Funeral director: W. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 1 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1948 at 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1948 to Oct 30 1948 and that I last saw her alive on Oct 30 1948

Immediate cause of death	Duration
Coronary Occlusion	24 hours
Due to Myocarditis	8 mos
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 382 Gorsuch Ave Date signed Oct 31 48

VS 150

68184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkins ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 7 18

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No 5225 Reisters Town Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Dora C. Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife Nelson E. Snyder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1860

8. AGE: Years	Months	Days	If less than one day
88	1	6	hr. min.

9. Birthplace Port Republic, Va.
(Town, county and state)

10. Usual Occupation Housewife Retired

11. Industry or business

FATHER
12. Name Baldwin Harris
13. Birthplace Va. d'ec'd

MOTHER
14. Maiden Name Elizabeth Lawrence
15. Birthplace Va.

16 (a) Informant Mrs. Kluth, Daughter
(b) Address Groveland ave 4105

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville 8, Md.

18 (a) Funeral director WM. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 50 P.

20. DATE OF DEATH 10-31 1948 at 8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1948 to 10-31 1948 and that I last saw h-- alive on 10-31 1948

Immediate cause of death acute diffuse peritonitis. — Duration one wk

Due to Incarcerated hernia (Inguinal) with gangrene ? .

Due to & perforation.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-22-48

Major findings of operation: Incarcerated Inguinal hernia, left. Gangrenous ileum & perforation

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. W. Sherwin M. D.
Address St Agnes' Hosp Date signed 11-1-48

L. W. Sherwin

VS 150

G68185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 Registered No. G68185

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Church Home
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Broadway & Fairmount (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Jemima Bridgeford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. ~~Single~~ widowed

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 8, 1861

8. AGE: Years 87 11111 | Months 7 — | Days 22 | If less than one day hr. min.

9. Birthplace ? Scotland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Bridgeford
13. Birthplace Scotland

MOTHER
14. Maiden Name Agnes Valentine
15. Birthplace Scotland

16 (a) Informant Miss Jemima Bridgeford
(b) Address Church Home

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30/1948 at 7.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1948 to 10/30 1948 and that I last saw her alive on 10/30 1948.

Immediate cause of death Cardiac failure — Duration —
Due to myocardial CVD
Due to grade IV decompensation
Due to Arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. W. Mintz M. D.
Address Church Home Date signed 10/31/48

VS 130

G68186 ✓ G68186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9 r 6

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5809 Reisterstown Rd
(c) Hospital or institution: 7-19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5809 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Maria Louisa Reisinger

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) ~~Single~~, married, widowed, or ~~divorced~~: Widowed
6 (b) Name of husband or wife: Charles F Reisinger
6 (c) If alive, give age: yrs.
7. Birth date of deceased (mo., day, yr.) Jan-9-1861
8. AGE: Years 87 | Months ~~12~~ | Days 21 | If less than one day: hr. min.
9. Birthplace Reisterstown Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name John W Speidlitz
13. Birthplace Reisterstown Md

MOTHER
14. Maiden Name Lydia Knight
15. Birthplace Hospital, Md

16 (c) Informant Mrs Ella A Neal
(b) Address 5809 Reisterstown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville 8, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 1 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30th 1948, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1947 to Oct 30 1948, and that I last saw her alive on Oct 28 1948.

	Duration
Immediate cause of death Chronic I. 1. mitral Endocarditis	Unknown
Due to 2. Arterio-Sclerosis	10 yrs
Due to 3. Senility	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. B. Ensor M. D.
Address 7201 York Rd Date signed 10-20-48

VS 8

G68187

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G68187
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 West Rogers Ave.
(c) Hospital or institution: Home for the Aged of the Meth. Ch.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27-15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SADIE RATHELL COTTINGHAM

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Walter Cottingham
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Feb. 28, 1869

8. AGE: Years	Months	Days	If less than one day
79	8	2	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Rathell
13. Birthplace Eastern Shore, Md.

MOTHER
14. Maiden Name Eliza C. Krebs
15 Birthplace Balto., Md.

16 (a) Informant Miss Miriam O. Coates, Supt.
(b) Address Home for the Aged of the Meth. Ch.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1948 at 11:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1948 to Oct 29 1948 and that I last saw h[illegible] alive on Oct 29 1948.

Immediate cause of death	Duration
Cerebral hemorrhage	6 days
Due to Arterio sclerosis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur J. Davies, M. D.
Address 800 W 33rd St Date signed 11-1-48

VS 150

G68188

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93 2

G68188 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 S. Collington
(c) Hospital or institution: 1-05

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 S. Collington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella May OLIVER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Benjamin F. Oliver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1880

8. AGE: Years 68 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Charleston, W. Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert W. Peaco
13. Birthplace

MOTHER
14. Maiden Name Emma Jenkins
15. Birthplace

16 (a) Informant Mrs. Joseph Wilson
(b) Address 1601 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-48

(c) Cemetery or crematory Oak Lawn
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & Sons
(b) Address Balto., Md.

19 NOV 1 1948 (Date rec'd by registrar) Registrar for Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30/48 19 10:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While
(d) Means of injury

23. Signature John R. Travers, M.D.
Medical Examiner.
Date signed 10/31/48

68189

Medical Examiners Case
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 68189

GM. 124088

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1251 Riverside Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Crane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July -29-1871

8. AGE: Years	Months	Days	If less than one day
77	3	1	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

CERTIFICATION APPROVED BY
Howard J. Madden, M.D.
For: Wm. G. Helfrich M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) [illegible] 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 - 1948, at 12.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26- 1948 to 10-30- 1948, and that I last saw h in alive on 10-30- 1948

Immediate cause of death	Duration
Uremia	days
Due to Hypertensive Cardio-Vascular disease	?
Due to	
Other Conditions Gradual Sinking	7 days

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 23/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence October 24, 1948 at ? M
(c) Where did injury occur? Baltimore, Maryland
S.W. corner Charles & Cross (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public place While at work? no
(Specify type of place)
(e) Means of injury Tripped and fell to street

23. Signature Norman F. Lord, M.D. M. D.
Address 1940 Eastern Ave Date signed 11-25-48

VS 159

To Be Approved By Medical Examiner.

668190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d ✓ Registered No. 668190

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave and Madison
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 11-03

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 W Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Wheeler

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-22-9557

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1884

8. AGE: Years	Months	Days	If less than one day
64	7	24	hr. min.

9. Birthplace York, Penna. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name William G. Wheeler
13. Birthplace Baltimore

MOTHER
14. Maiden Name Augusta E. Wilhelm
15. Birthplace Baltimore

16 (a) Informant Mrs. Oliver Eckhart
(b) Address 13 Cedar Ave., Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location

18 (a) Funeral director Charles F. Evans & Son
(b) Address 118 W. Mt. Royal Ave.

19 (a) Nov 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1948 at 7 30 P M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Peter B. McFadden M.D. Medical Examiner.
Date signed 10-31-48

G68191

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

167 Registered No. G68191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 543 Layfayette Street Ave W. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie (Weaver) BENNER

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-2336

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1903

8. AGE: Years 45 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Florence, S. C.
10. Usual Occupation Chef
11. Industry or business ?

FATHER
12. Name Unknown
13. Birthplace South Carolina

MOTHER
14. Maiden Name Unknown
15. Birthplace South Carolina

16 (a) Informant: Lizzie Watkins
(b) Address 717 Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead Reed
(b) Address 96 E. Lafayette ave.

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Baltimore, Md.

VS 1?

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1948, 9:35 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of Aorta

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-31-48 at P. M.
(b) Where did injury occur? Lafayette & Brunt Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp Instrument

23. Signature Emil L. Beyer M.D.
Medical Examiner.
Date signed 11-1-48

X

668192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 668192

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 205 N. Lakewood Ave
(c) Hospital or institution: L-O-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Lakewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Giulia Biscotti

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No.: NONE

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband Xxxxx Michele Biscotti

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28 1878

8. AGE: Years	Months	Days	If less than one day
70	8	3	hr. min.

9. Birthplace Lama di Peligna -Chieti- Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Nicola Sebastiani
13. Birthplace Italy

MOTHER
14. Maiden Name Maria ?
15. Birthplace Italy

16 (a) Informant Michele Biscotti (Husband)
(b) Address 205 N. Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3rd/48 (month) (day) (year)
(c) Cemetery Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 900 S. High St.

19 NOV 1 1948 (Date rec'd by registrar) (by) Creighton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1948 at 2:35 P M

21. I certify that I took charge of the remains described above, held an Ext & Insp Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Kelbach M.D.
Medical Examiner.
Date signed Oct 31, 1948

VS 151

668193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668193

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 N. Duncan St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 N. Duncan St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Bornicak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John Bornicak

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. 2-2-1882

8. AGE: Years	Months	Days	If less than one day
66	8	29	hr. min.

9. Birthplace Austria-Hungary (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name John Placeto

13. Birthplace Austria

MOTHER 14. Maiden Name Not known

15. Birthplace Austria

16 (a) Informant John S. Bornicak

(b) Address 1417 N. Duncan

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto Md

18 (a) Funeral director Mayer Brock & Son

(b) Address [illegible]

19 NOV 1 1948 (b) [illegible]
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31, 1948 at 1:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 1 1947 to Oct 31 1948 and that I last saw h.. alive on Oct 24 1948

Immediate cause of death	Duration
Acute Coronae Failure	1 day
Due to	
Due to	
Other Conditions Cancer of the Uterus	1 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Race M.D. M. D.

Address 2413 E Monument St Date signed 11/1/48

VS 150

G68194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G68194

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 N. Patterson Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 N. Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Matula

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Matthew Matula
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1876

8. AGE: Years 71 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation House work
11. Industry or business

FATHER
12. Name John Skibinska
13. Birthplace Austria

MOTHER
14. Maiden Name Not known
15. Birthplace Austria

16 (a) Informant Frank Matula
(b) Address 513 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-48 (month) (day) (year)
(c) Cemetery or crematory Holy Sepulcher
Location Baltimore Md

18 (a) Funeral director Frank Brockdorf
(b) Address 2406 Chester St

19 (a) NOV 1 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1948 at 6:10 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1 1947 to Oct 28 1948, and that I last saw h[er] alive on Oct 28 1948.

	Duration
Immediate cause of death: Coronary Thrombosis	10/26/48
Due to: Chr. Myocarditis	9/1/47
Due to: Hypertensive Cardio vascular disease	9/1946
Other Conditions: Generalized arterio-sclerosis	9/1944

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Bauer M. D.
Address 801 N. Eutaw St Signed 10/29/48

VS 150

68195
AB-124068

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

48-24209 159

Registered No. 68195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 S. Amity St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Falcon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 26-1948

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth Falcon
15. Birthplace N.C.

16 (a) Informant Records, Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 10-28-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory B. C. Hosp.
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) Date received NOV 1 1948 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27- 1948, at 12.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26- 1948 to 10-27- 1948, and that I last saw him alive on 10-27- 1948

Immediate cause of death: Prematurity — Duration: 1day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Date signed 10-29

8196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C68196

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 244 S. Durham St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 244 S. Durham St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Stanley Stackowits

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 1, 1910

8. AGE: Years	Months	Days	If less than one day
38	0	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Machanist
11. Industry or business

FATHER
12. Name William Stackowitz
13. Birthplace Poland

MOTHER
14. Maiden Name Carrie ?
15. Birthplace Poland

16 (a) Informant Lottie Tiletsky
(b) Address 121 S. Register St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 2 48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 103 S. Wolfe St. Baltimore 31, Md.

19 NOV 2 1948 (b) Huntingdon Pa. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1948, at 6:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 , to Oct 29 1948 and that I last saw him alive on Oct 29 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Coronary occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Sborofsky M.D.
Address 601 N. Monroe St. Date signed 11/1/48

VS 150

G68197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 a

Registered No. G68197

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 N. Lakewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 N. Lakewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Hammen

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-2487

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alice V. Hammen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1887

8. AGE: Years	Months	Days	If less than one day
61	1	15	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Hammen
13. Birthplace Unknown

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Alice V. Hammen
(b) Address 20 N. Lakewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herrington Sons
(b) Address 2024 Orleans St.

19 (a) Nov 2 1948 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30/48 1948 at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-26 1948 to Oct 30 1948
and that I last saw h/m alive on Oct 30 1948

Immediate cause of death ARTERIOSCLEROSIS — Duration 3 YRS
due to CVA INT NOOM. — 3 YRS
Due to (Conditions, if any, giving rise to the immediate cause stated, stating the underlying cause last.) —
Due to — (?)
Other Conditions HYPERTENSION
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work; (Specify type of place)
(e) Means of injury

23. Signature James F. Kavanaugh M.D.
Address 3014 McElderry Date signed Nov-1-48 M. D.

VS 180

X

G68198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95C

G68198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Frances H. Voertman

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
NO	NO	FM	White	Widowed

6 (b) Name of husband or wife George A. Voertman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 23, 1866

8. AGE: Years	Months	Days	If less than one day
82	0	8	hr. min.

9. Birthplace Wisconsin (Town, county, and state)
10. Usual Occupation Home
11. Industry or business Home

FATHER
12. Name Micheal Hettinger
13. Birthplace New York

MOTHER
14. Maiden Name Elizabeth Reid
15. Birthplace Kentucky

16 (a) Informant Mary E. Voertman
(b) Address 406 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director John T. Stansbury
(b) Address 2700 Edmondson Ave.

19 (a) NOV 2 1948 (b) Huntington Williams M.D. Registrar
Date rec'd by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1948 19 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1948 to Oct. 31 1948, and that I last saw her alive on 10-30-1948.

Immediate cause of death: Organic Heart Disease — Duration: Unknown

Due to

Due to

Other Conditions: Influenza — 10 da.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chester Riland M. D.
Address 2532 Edmondson Ave Date signed 11-1-48

VS 153

G68193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 c

G68199 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9-08
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 Kennedy Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andy Pavlicsak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed or divorced~~
Male	White	Married

6 (b) Name of husband or wife Julia Ann Pavlicsak 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1892

8. AGE: Years	Months	Days	If less than one day
56	2	0	hr. min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Joseph Pavlicsak
13. Birthplace Hungary

MOTHER
14. Maiden Name Ann Asch
15. Birthplace Hungary

16 (a) Informant Julia Ann Pavlicsak
(b) Address 1911 Kennedy Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore MD
Location Baltimore

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 NOV 2 1948 (Date rec'd by Registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Oct 1948, at 4:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy / Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of Skull c
intra-cranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 9-8
(a) Date of injury 31 Oct 48 at 12:45 A.M.
(b) Where did injury occur? Kennedy & Pratt Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by Auto

23. Signature Emil L. Rogy M.D.
Medical Examiner
Date signed 31 Oct 48

VS 181

668200

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

Registered No. 668200

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Charles & Mt. Vernon Place
(c) Hospital or institution: Washington Apts. 1
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Charles St. & Mt Vernon Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: VIRGINIA R. WINDER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	None	Female	White	Married

6 (b) Name of husband or wife: John H.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 11, 1867

8. AGE: Years	Months	Days	If less than one day: hr.	min.
81	0	19		

9. Birthplace: New York (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Charles Ransom
13. Birthplace: New York

MOTHER
14. Maiden Name: Georgia Anderson
15 Birthplace: Maryland

16 (a) Informant: Mohn H. Winder
(b) Address: Washington Apts, Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Baltimore, Md.

18 (a) Funeral director: William Cook, Inc
(b) Address: 1217 St. Paul St.

19 NOV 2 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 30, 1948 19 , at 4 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Oct 30 1948, and that I last saw h[illegible] alive on Oct 30 1948.

Immediate cause of death — Duration

Myocarditis
Cardiac Sclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: H. B. Headley M. D.
Address: 1403 Park Ave Date signed: 11/1/48

VS 190

68201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 68201

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1929
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 54 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 St. Paul Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Italy

3 (a) FULL NAME CAROLINE PIRRONE

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	married

6 (b) Name of husband or wife Anthony Pirrone
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) October 12, 1877

8. AGE: Years	Months	Days	If less than one day
71	0	19	..... hr. ..... min.

9. Birthplace Italy (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Augustine (?)
13. Birthplace Italy

MOTHER
14. Maiden Name Pirrone (?)
15. Birthplace Italy

16 (a) Informant Vincent Pirrone (son)
(b) Address 1929 St. Paul St

17 (a) Entombment (b) Date thereof 11/4/48 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Corp
Location Baltimore Md

18 (a) Funeral director Fellows & Lee
(b) Address 1219 N. Paul St

19 (a) Filed Nov 2 1948 (b) Transcription for Baltimore, Md. (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1948 at 9 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1948 to 10/31 1948.
and that I last saw h e r alive on 10/31 1948.

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to Coronary sclerosis	
Due to	
Other Conditions Cardiac failure; Residual of Cerebral Accident; Diabetes Mellitus; Generalized arteriosclerosis (Operations within 3 months of death)	over

Date of operation
Major findings of operation:
of autopsy: Adrenal tumor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. A. Harris
Address Md. Gen'l. Hosp. Date signed 11/1/48

VS 190

914

68202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68202

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 1649 East 25th Street
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1649 East 25th Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LESSIE W. ENTLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Feamale	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 7, 1872

8. AGE: Years	Months	Days	If less than one day
76	1	23	hr. min.

9. Birthplace Shepherdstown, W.Va. (Town, county, and state)
10. Usual Occupation Practical Nurse
11. Industry or business

FATHER
12. Name John P. Entler
13. Birthplace W.Va

MOTHER
14. Maiden Name Amelia Walters
15 Birthplace W.Va.

16 (a) Informant Mrs L. Rust
(b) Address 1649 E. 25th St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Elmwood
Location Shepherdstown, W.Va.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 NOV 2 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1948, at 6:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1945 to Oct 30 1948.
and that I last saw h[illegible] alive on Oct 30 1948.

Immediate cause of death Cerebral Hemorrhage — Duration
Due to Arteriosclerosis
Due to Cardiovascular Renal
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 11-1-48

VS 150

X

68203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No. 68203

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Fayette St.
(c) Hospital or institution:
Bon Secours Hospital 19 01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 S. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Placidus Rattenberger, O. S. B.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1892

8. AGE: Years	Months	Days	If less than one day
56	1	9	hr. min.

9. Birthplace Essenbach, Bavaria (Town, county, and state)

10. Usual Occupation Priest

11. Industry or business Pastor of 14 Holy Martyrs Church

FATHER
12. Name Adam Rattenberger
13. Birthplace Essenbach, Bavaria

MOTHER
14. Maiden Name Johanna Flugel
15. Birthplace Mettenbach

16 (a) Informant Rev. Roland
(b) Address 101 S. Mount St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 2/48. (month, day, year)
(c) Cemetery or crematory St. Vincents
Location Latrobe, Pa.

18 (a) Funeral director Harry H. Nitsche
(b) Address 4101 Edmondson Ave. Baltimore, Md.

19 (a) Date received by Registrar NOV 2 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29/48 19 , at 11:50 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? (Write or specify)
(d) Means of injury

23. Signature John R Ward, M.D.
Medical Examiner.

Date signed 11/1/48

668204

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a ✓ Registered No. 668204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1905 E. Lafayette Ave.
(c) Hospital or institution:
8 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md, (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 E. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ADAM RENTSCHLER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-03-2277

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Beatrice M.

6 (c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): April 18, 1889

8. AGE: Years 59 | Months 6 | Days 12 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Race Track worker

11. Industry or business

FATHER
12. Name: Adam Rentschler
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna M. Grossman
15. Birthplace: Germany

16 (a) Informant: Mrs. Adam M. Rentschler
(b) Address: 1905 E. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 NOV 2 1948 (Date rec'd by registrar) (b) Huntington Nelligan, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1948 at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Oct 30 1948. and that I last saw him alive on Oct 29 1948.

	Duration
Immediate cause of death: Myocardial Insufficiency	2 years
Due to: Coronary Sclerosis	5 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed Oct. 4

VS 159

X

68205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68205

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 58 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 05

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1740 Darley Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIAN BAERSCHMIDT

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Adam A. Baerschmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1874

8. AGE: Years: 73 | Months: 10 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER 12. Name: John C. Fink
13. Birthplace: Maryland

MOTHER 14. Maiden Name: Dora Metz
15. Birthplace: Maryland

16 (a) Informant: Adam A. Baerschmidt
(b) Address: 1740 Darley Ave. #13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (Date rec'd by Registrar) NOV 2 1948 Waverly Funeral Home, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1948, at 1 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1948 to 10/31 1948, and that I last saw h alive on 10/30 1948.

	Duration
Immediate cause of death: Cardio-respiratory Failure	
Due to: Cerebral Accident	9 days
Due to: Hypertensive + A.S.H.D.	10 yrs.
Other Conditions: Hypertrophic Arthritis (Include pregnancy within 3 months of death)	

Date of operation: None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W. A. Harris
Address: Md. Gen'l Hosp. Date signed 10/31/48 M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 199

X

G68206

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 169

Registered No. G68206

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 1-05
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD NELSON

3 (b) If veteran, name war NO

3 (c) Social Security Account No. 216-10-5043

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Amelia

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 28, 1895

8. AGE: Years 53 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Norway (Town, county, and state)

10. Usual Occupation
11. Industry or business Arundel Sand & Gravel

FATHER
12. Name Matti Nelson
13. Birthplace Norway

MOTHER
14. Maiden Name Mary ?
15. Birthplace Norway

16 (a) Informant Mrs. Amelia Nelson
(b) Address 2100 E. Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Avenue and Broadway

19 (a) NOV 2 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1948 at 4:40 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed chest

Due to

Other Conditions Acute dilatation

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-31-48 at ? P. M. 3/2
(b) Where did injury occur? Foot of Bond Street
(c) Did injury occur at home, on farm, industrial place, in public place? public Whil at work? no
(d) Means of injury Ran into box car and dragged

23. Signature Earl K. Rose M.D. Medical Examiner
Date signed 10-31-48

VS 191

68207

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 68207

GM. 123867

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 E. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Foster Copeland (FOSTER HARVEY COPELAND)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-07-6193

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Maude M.
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1880

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	8	17		

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Store Manager
11. Industry or business Beth. Steel Co. Sp. Pt.

FATHER
12. Name John Copeland
13. Birthplace N.C.

MOTHER
14. Maiden Name Esther Copeland
15. Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) NOV 2 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by reg'r)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31- 1948 5.50P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10- 19- 1948 to 10- 31- 1948. and that I last saw him alive on 10- 31 - 1948

Immediate cause of death	Duration
Uremia	?
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Erythema (including pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 7140 Eastern Ave. Date signed 11/3/48

VS 150

68208

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 68208

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Street
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Chestertown (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Lewis Meekins

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	S

6 (b) Name of husband or wife 0
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1946

8. AGE: Years	Months	Days	If less than one day
1	11	?	hr. min.

9. Birthplace Chestertown, Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Lewis Meekins
13. Birthplace Md

MOTHER
14. Maiden Name Lillie Morris
15. Birthplace Md.

16 (a) Informant Father or Mother
(b) Address Chestertown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-48 (month) (day) (year)
(c) Cemetery or crematory Chestertown
Location Chestertown, Md

18 (a) Funeral director Edgar L. Price
(b) Address Chestertown, Md

19 (a) NOV 2 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1948 at 2:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1948 to Nov. 2 1948, and that I last saw him alive on Nov. 2 1948

Immediate cause of death	Duration
Respiratory failure	
Due to Laryngeal obstruction	
Due to Acute laryngo-tracheitis	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation 11/2/48
Major findings of operation: Laryngeal obstruction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. F. Pleasants M. D.
Address University Hospital Date signed 11/2/48

VS 150

668209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 668209

A64666 B. C.-48-1645

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 Fountain, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette Licharowicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/7/48

8. AGE: Years	Months	Days	If less than one day
	2 1/2		hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Martin Licharowicz
13. Birthplace Baltimore

MOTHER
14. Maiden Name Josephine Murphy ?
15. Birthplace Baltimore

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 2 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Church
Location Balto. County

18 (a) Funeral director John J. Weber
(b) Address 401 E. Chester Street

19 (a) NOV 2 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-1- 1948 at 4 15- A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31- 1948 to 11-1- 1948 and that I last saw h[illegible] alive on 11-1- 1948.

Immediate cause of death Pneumonia and Atelectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 11-1-48 at 4 15 M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Ryan M. D.
Address Johns Hopkins Hospital Date signed 11-1-48

668210

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

462

668210 Registered No.

Please write the entries in black ink clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave.
(c) Hospital or institution: 1702
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 737 Dolphin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Armstead

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife John H. Armstead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1871

8. AGE: Years	Months	Days	If less than one day
77	1	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. H. Walker
13. Birthplace Md.

MOTHER
14. Maiden Name Virginia Cooper
15. Birthplace Md.

16 (a) Informant John H. Armstead
(b) Address 737 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) NOV 3 1948 (Date rec'd by Registrar) Huntington for Williams Registrar

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH NOV. 1, 1948, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1948, to 11-1 1948, and that I last saw h alive on Nov 1 1948.

Immediate cause of death Carcinoma Rectum

Duration 7

Due to (Carcinoma)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 561 Dolphin St Date signed 11-7-48

68211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51d ✓

Registered No. 68211

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 29 N Carey St

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 year

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2322 Guilford ave (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/8/1897

8. AGE: Years	Months	Days, if	If less than one day
51	8	20	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Colman Fields

13. Birthplace Va

MOTHER 14. Maiden Name Lucy Carter

15. Birthplace Va

16 (a) Informant William Field

(b) Address 2007 Druid Hill ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location A. A. Co

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

19 (a) NOV 2 1948 (Date rec'd by registrar) (b) Washington Baltimore (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1948 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1948 to Oct 29 1948, and that I last saw h alive on 19

Immediate cause of death	Duration
(a) Acute Myocarditis	Days
Due to (b) Cancer Rectum	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Walter J Gomez M. D.

Address 401 N Edmondson Date signed 11-2-48

VS 1-50

68212

BALTIMORE CITY HEALTH DEPARTMENT 93 d ✓ Registered No. 68212

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 846 W. 33rd St.
(c) Hospital or institution: 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 846 W. 33rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT FRANKLIN DAVIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Helen Davis
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) April 5, 1891

8. AGE: Years	Months	Days	If less than one day
57	6	26	hr. min.

9. Birthplace Parkton, Md. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Continental Can Co.

FATHER
12. Name Benjamin G. Davis
13. Birthplace Md.

MOTHER
14. Maiden Name Emma R. Miller
15. Birthplace Md.

16 (a) Informant Mrs. Helen Davis
(b) Address 846 W. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 2 1948 (Date rec'd by registrar) (b) Kenneth Robinson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 31, 1948, at 11:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1934 to October 1948, and that I last saw h im alive on October 29 1948.

Immediate cause of death	Duration
Congestive heart failure	
Due to Hypertensive cardiovascular disease	
Due to Coronary artery insufficiency.	
Other Conditions Aortic insufficiency.	

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ira E. Gayer M.D.
Address 11 E. Chase St. Date signed 11.2.48

VS 150

68213

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

✓ 68213 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Nursing Home 19-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY A. APPLEBY

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	none	female	white	widow

6 (b) Name of husband or wife William Appleby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 10, 1879

8. AGE: Years	Months	Days	If less than one day
69	7	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Herman C. Frentz
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Dueffelsdorf
15 Birthplace Bremen, Germany

16 (a) Informant Mr. Herman N. Frantz ✓
(b) Address 326 N. Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 2 1948 (Rec'd by registrar) (b) Tennington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1948 at 4:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13, 1948 to Oct. 30, 1948. and that I last saw her alive on Oct. 30, 1948.

	Duration
Immediate cause of death Congestive heart failure	
coma & dehydration	10 days
Due to Cerebral Apoplexy	one year
Due to Arterio-sclerosis with hypertension	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice F. Skaggs M. D.
Address 3 Bond St. Balto. Md. Date signed 11/2/48

VS 150

X

668214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668214

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 W..Lanvale Street
(c) Hospital or institution: 17-0

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 W. Lanvale Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME VICTORIA A. BUTLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife William H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) October 7, 1860

8. AGE: Years	Months	Days	If less than one day
88	-	24	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Jackson
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Catherine Jacques
15. Birthplace Unknown

16 (a) Informant Mrs. William H. Martin
(b) Address 515 W. Lanvale Street

17 (a) Burial (b) Date thereof Nov. 3, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 NOV 2 1948 (b) [signature] Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1948 at 3:15 a/ M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1948 to Oct 31 1948.
and that I last saw her alive on Oct. 31 1948.

Immediate cause of death

	Duration
Due to arteriosclerotic cardio-vascular - renal disease	48 hrs
Due to	10 mos.
Other Conditions senility	7.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D. Carr M.D.
Address 515 Walker Rd Date signed Nov 2 48

VS 150

668215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3a ✓ Registered No. 668215

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 E.Lanvale Street
(c) Hospital or institution: 8 06
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 E.Lanvale Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Schmidt

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 220-24-1486

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Matilda C.Knepper
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Feb.28th.,1874

8. AGE: Years	Months	Days	If less than one day
74	8	3	########## min.

9. Birthplace Baltimore,Maryland
(Town, county, and state)
10. Usual Occupation Retired,Musician
11. Industry or business

FATHER
12. Name Charles Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Kopp
15. Birthplace Germany

16 (a) Informant Mrs.Matilda C.Schmidt (Wife)
(b) Address 1619 E.Lanvale Street

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Avenue,Balto:Md.

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue

19 (a) NOV 2 1948 (Date rec'd by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31st., 1948 at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug.4, 1948 to Oct.31,1948. and that I last saw him alive on Oct.30, 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage & Hemiplegia	2mo.
Due to Arteriosclerosis	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1513 E.North Ave. Date signed 11-1-48

V S 150

668216 Bowler

BALTIMORE CITY HEALTH DEPARTMENT ✓ 9 r d

CERTIFICATE OF DEATH

Registered No. 668216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Un. Hospital
(c) Hospital or institution: 12-13
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2365 McCulloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lydia Bowler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widowed.

6 (b) Name of husband or wife Robert. Dead. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/3/1902

8. AGE Years	Months	Days	If less than one day
46	9	28	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Joseph Isaac
13. Birthplace Md

MOTHER 14. Maiden Name Mary Howard
15. Birthplace Md

16 (a) Informant Mamie Turner
(b) Address 2365 McCulloh

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/48 (month) (day) (year)
(c) Cemetery or crematory Longview
Location Longview, Md

18 (a) Funeral director Wm. H. Nelson
(b) Address 1300 Pennsylvania Ave

19 (a) NOV 2 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1948, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29 1948, to Nov 1 1948, and that I last saw her alive on Oct. 31 1948.

Immediate cause of death	Duration
Cardiac arrest.	
Due to Chronic interstitial disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Bonsal M.D. M. D.
Address Un. Hosp. Date signed 11/5/48

VS 150

Vital statistics, laws, regulations, etc., please write the causes of death clearly and legibly.

68217

GM. 123941

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

0138 Registered No. 68217

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 4-62
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 659 Vine ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Dates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife Susie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14 [illegible]

8. AGE: Years	Months	Days	If less than one day
32	✓	16	hr. min.

9. Birthplace VA.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alfred Dates
13. Birthplace VA.

MOTHER
14. Maiden Name Martha?
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Cresleman St

19 (a) [illegible] 1948 (Date received by registrar) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10- 30 - 1948 at 6.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10- 21 -19 48 to 10-30 - 1948. and that I last saw him alive on 10-30 - 48

Immediate cause of death Respiratory failure — Duration

Due to Tuberculous meningitis — 2 yrs.

Due to Pulmonary tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulm tuberculosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Gayle Burton M. D.
Address Baltimore City Hospitals Date signed 11/1/48

VS 150

68218

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

930 V

Registered No. 68218

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3619 White Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3619 White Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew Weng or Wengrynowicz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bessie Weng | 6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, and year) Not Know

8. AGE: Years About 60 | Months | Days | If less than one day: hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ? Weng
13. Birthplace Austria

MOTHER
14. Maiden Name Not Know
15. Birthplace Austria

16 (a) Informant Mrs. Bessie Weng
(b) Address 3619 White Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3-48 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Edgewood Rd

18 (a) Funeral director John J. Grebiancke Jr.
(b) Address 1423 S Paca St

19 [illegible] 2 1948 Washington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1948 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1948 to Oct 30 1948. and that I last saw him alive on Oct 24 1948.

	Duration
Immediate cause of death: Congestive heart failure	2 mo.
Due to: Arteriosclerotic Heart disease	many yr.
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mot R. English M. D.
Address 5113 Belair Rd Date signed 11-1-48

VS 150

X

8219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. B-44219

(68-19)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 S. Collins Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 S. Collins Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Edward Leo Quinn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Annie Quinn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7, 1866

8. AGE: Years	Months	Days	If less than one day: hr.	min.
82	1	30		

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Quinn
13. Birthplace Md.

MOTHER
14. Maiden Name Johnna Hankamp
15. Birthplace Md.

16 (a) Informant Mrs. Annie Quinn
(b) Address 503 S. Collins Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George D. Hanley
(b) Address Fulton Ave & Fayette St.

19 (a) NOV 3 1948 (Date received by registrar) (b) Washington Millimans, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1948 to Nov. 1 1948, and that I last saw h alive on Oct 26 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	11 days
Due to arterio Sclerosis	
Due to a Hypertension	5 yr.
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify one) While at work?
(e) Means of injury

23. Signature W. H. Hanson M.D.
Address 1711 Selma Ave Date signed 11/1/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

8220 ✓ 68220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 68220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St
(c) Hospital or institution:
Home of Our Lady of
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 34 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 E. 22nd St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Isabelle Louise Dwyer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 23 1864

8. AGE: Years	Months	Days	If less than one day
84	6	8	hr. min

9. Birthplace Chestertown, Kent Co Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John W Dwyer
13. Birthplace Chestertown Md

MOTHER
14. Maiden Name Rose Hyder
15. Birthplace Bristol, England

16 (a) Informant Albert V Dwyer
(b) Address 509 E 22nd St. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE. & 22nd ST.

19 (a) NOV 3 1948 (Date rec'd by registrar) (b) Burial Permit Issued

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30/48 19 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948 to Oct 9 1948 and that I last saw her alive on Oct 9 1948.

Immediate cause of death Cerebral Hem. b/c — Duration 4 mo.

Due to Hypertension

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 753 W. Lafayette Ave Date signed 11-1-48

VS 150

21 X ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1948 Registered No. 168221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway and Fairmount Ave.
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 days

2. USUAL RESIDENCE OF DECEASED: Same
(a) State Maryland (b) County Caroline
(c) City or town Mount Airy
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 2
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs. Myrle Logue

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife Mr. Milford Logue
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) 2-28-11

8. AGE: Years	Months	Days 4	If less than one day
37	8	21	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Henry Ogg
13. Birthplace Maryland

MOTHER
14. Maiden Name Eunice Fleter
15. Birthplace Maryland

16 (a) Informant Lawrence Betty Webster
(b) Address Church Home & Hosp. records

17 (a) BURIAL (b) Date thereof NOV 5 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Deer Park Cem
Location Near Westminster, Md.

18 (a) Funeral director John R. Byers
(b) Address Westminster, Md.

NOV 3 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2 1948, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1948 to 11-2 1948, and that I last saw h er alive on 11-2 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Inanition	
Due to	
Other Conditions cirrhosis of liver splenomegaly, ascites	

(Include pregnancy within 3 months of death)
Date of operation 9-29-48 and 10-19-48
Major findings of operation: Ascites, splenomegaly, cirrhosis of liver
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard M. Garrett M. D.
Address Church Home + Hosp Date signed 2 Nov 48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. 1668

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3615 Sixth Street
(c) Hospital or institution: 75-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3615 Sixth Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha M. Hildebrandt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/25/1855

8. AGE: Years	Months	Days	If less than one day
93	8	6	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Hildebrandt
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Wensel
15. Birthplace Germany

16 (a) Informant Family
(b) Address Same

17 (a) B (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Maryland

18 (a) Funeral director James L. Williams
(b) Address 130 East Fort Avenue

19 (a) Nov 3 1948 (Date rec'd by Registrar) (Signature of Registrar) Millington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1948, at 6 4, M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Oct 27, 1948 and that I last saw him alive on Oct 27 1948.

Immediate cause of death	Duration
(a) Hypostatic pneumonia	6d
Due to (b) Arteriosclerosis	
Due to (c) Senile decay	
Other Conditions Old age.	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature [illegible] M. D.
Address 5 E. Lexington St. Date signed Nov 4 48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 ✓

Registered No. G68[illegible]23

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4904 Elmer Ave.
(c) Hospital or institution: 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4904 Elmer Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Edythe A. McCann - ALSO KNOWN AS - Edith H. McCann

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-2310

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Joseph H. McCann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1892

8. AGE: Years	Months	Days	If less than one day
56	2	30	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Demonstrator
11. Industry or business General Flour Mills

FATHER
12. Name William Amos
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Fillinger
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Raymond J. McCann
(b) Address 4904 Elmer Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Ceme.
Location Baltimore, Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1948 at 12.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/8/48 19.. to 10/30/48, and that I last saw her alive on 10/30 1948.

	Duration
Immediate cause of death Bronchopneumonia	3 days
terminal	
Due to Carcinoma-Lung	1 yr.
Due to Metastasis from breast (rt)	2½ yrs
Other Conditions Metastasis to liver and pancreas	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Randolph H. Berkley, M.D. M. D.
Address 5010 Denmore Ave. Date signed 11-1-48

V S 150

X [illegible]

8-224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 V Registered No. 668-24

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Road.
(c) Hospital or institution: Colonial Nursing Home. 7506
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6109 Fair Oaks Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Louisa Heinlein,

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 4, 1871

8. AGE: Years	Months	Days	If less than one day
77	1	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Heinlein,
13. Birthplace Germany,

MOTHER
14. Maiden Name Margaret Gissell,
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Margaret Cavey,
(b) Address 1908 W. Fairmount Ave.,

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Nov 1948, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1948, to 1 Nov 1948, and that I last saw h[illegible] alive on 1 Nov 1948.

Immediate cause of death	Duration
Chronic Congestive Heart Failure	
Due to Hypertension & C.V. Disease	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl Royer M. D.
Address 172 Washington Pl Date signed 2 Nov 48

V S 150

93d

68225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G68225 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3919 Ridgewood Ave.,
(c) Hospital or institution: 15 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3919 Ridgewood Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mathew Henry Fallon,

3 (b) If veteran, name war none

3 (c) Social Security Account No. 213-05-2507

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Margaret Fallon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1877

8. AGE: Years 71 | Months 9 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Menomonee, Wisconsin.
(Town, county, and state)

10. Usual Occupation Retired Salesman

11. Industry or business Meat Packing

FATHER
12. Name Patrick Fallon,
13. Birthplace Ireland.

MOTHER
14. Maiden Name Sabina Coughlin,
15. Birthplace Ireland.

16 (a) Informant Mrs. Margaret Fallon,
(b) Address 3919 Ridgewood Ave.

17 (a) burial (Burial, cremation, or removal) **(b) Date thereof** 11/6/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Milwaukee, Wisconsin.

18 (a) Funeral director B. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) NOV 3 1948 (Date rec'd by registrar) **(b)** Evelyn Williams, Asst. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1948 19 ... at 11.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1948 to 11/1/1948, and that I last saw him alive on 19 48.

Immediate cause of death Coronary Thrombosis.

Due to Hypertension,

Due to Pneumonia

Other Conditions Aortic Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Horton C. Fitch M. D.
Address 2151 Wilkins Ave. Date signed

V S 150

68-26

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

grd ✓

Registered No. G68-26

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1433 E. Federal Street
(c) Hospital or institution: 9-09
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 E. Federal Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CATHERINE M. STROTT

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles Strott

6 (c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): July 3, 1871

8. AGE: Years 77 | Months 3 | Days 27 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Jacob C. Pensel
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Buschmann
15. Birthplace: Germany

16 (a) Informant: Mr. Charles Strott
(b) Address: 1433 E. Federal Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/4/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 NOV 3 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Oct. 31 1948, at 2.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1948 to Oct 31 1948. and that I last saw h alive on Oct 31 1948.

Immediate cause of death: Chronic endocarditis — Duration: ?
Due to arteriosclerosis — 7 yr
Due to Hig[illegible] — 7 yr
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury?

23. Signature [illegible] M.D.
Address 915 S Broadway Date signed 11/1/48

VS 139

G68227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G68227

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 12-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Woodbrook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rebecca Adler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 70 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Morris
13. Birthplace: Russia

MOTHER
14. Maiden Name: Fanyie
15. Birthplace: Russia

16 (a) Informant: Morris Adler
(b) Address: 3400 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-48 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Mt Carmel
Location:

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 200 Eutaw Place

NOV 3 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3/ 1948, at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1/ 1948 to 11/3/ 1948, and that I last saw her alive on 11/2/ 1948.

Immediate cause of death: Carcinomatosis — Duration: over

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: CA

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B Harris M.D.

Address Sinai Hosp — Date signed 11/3/48

VS 150

68228

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61 ✓ G68228 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and Saratoga
(c) Hospital or institution: Mercy 7 or
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 N. Milton ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Janet Mc Ginnis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife George Mc Ginnis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 5, 1882

8. AGE: Years	Months	Days	If less than one day
66	7	26	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Meiser
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Annie Kramer
15. Birthplace Baltimore Md.

16 (a) Informant George E. Mc Ginnis
(b) Address 715 N. Milton ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2101 Orleans St.

19 (a) NOV. 3 1948 (Date rec'd by registrar) (b) Huntington Hollins

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/48 19.., at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1948 to 10/31 1948.
and that I last saw h[illegible] alive on 10/31 1948.

Immediate cause of death	Duration
Cardio respiratory failure	8 days
Due to Hypertensive Cardio vascular disease	indefinite
Due to Diabetes mellitus	indefinite
Other Conditions Uremia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph P. Brennan Jr. M.D.
Address Mercy Hospital Date signed 11-1-48

VE 139

68529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1940 ✓ Registered No. 68529

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital 2601
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5903 Kavon Avenue
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Conrad Workinger

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-2429

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) January 27, 1883

8. AGE: Years	Months	Days	If less than one day
65	9	4	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name William Workinger
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Schenkel
15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. Grace Spenner
(b) Address 5903 Kavon Ave.

17 (a) burial (Burial, cremation, or removal) **(b) Date thereof** 11/4/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Rd.

NOV 3 1948 (Date rec'd by Registrar) Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1948 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25/ 1948 to 11/1/ 1948 and that I last saw h im alive on 11/1/ 1948

Immediate cause of death	Duration
Acute Cardiac tamponade	
Due to Rupture of left ventricle through a myocardial infarct	
Due to Coronary Thrombosis	5 days
Other Conditions Sigmoid diverticulosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac tamponade

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no; place)
(e) Means of injury

23. Signature J. Joseph Kuzia M.D.
Address 1400 N Caroline St Date signed 11-1-48

VS 159

68230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

490 Registered No. 68230

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 McCullough St.
(c) Hospital or institution: 12-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 McCullough St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Eliza Pierson Ross.

3 (b) If veteran, name war ——

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Vincent Ross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1910

8. AGE: Years	Months	Days	If less than one day
38	6	28	hr. min.

9. Birthplace Howard Co Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name Wm Pierson
13. Birthplace Md

MOTHER 14. Maiden Name Ida Henson
15. Birthplace Md.

16 (a) Informant Vincent Ross
(b) Address 2304 McCullough St Balto 17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-1948 (month) (day) (year)
(c) Cemetery or crematory Locust Chapel
Location Catonsville Md.

18 (a) Funeral director J.C. Higinbotham
(b) Address Ellicott City Md

NOV 3 1948 (Date rec'd by Registrar) (b) Huntington Williams, Md Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1948, at 6:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1948 to Nov 1, 1948 and that I last saw h[illegible] alive on Nov 1, 1948.

Immediate cause of death
Carcinoma
Ovary

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Intrieri M. D.
Address 2331 Eutaw Pl Date signed Nov 1, 1948

68231

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d ✓ G68231 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3-0 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL A. THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1893

8. AGE: Years	Months	Days	If less than one day
54	11	14	hr. min.

9. Birthplace Balto. 1, Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name John Thomas
13. Birthplace Balto. 1, Md.

MOTHER 14. Maiden Name Annie
15. Birthplace Balto. Md.

16 (a) Informant Mary Crawley
(b) Address 1312 N. Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Brooklyn, Md.

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Brantly Ave.

19 (a) NOV 3 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1948, at 4:20A M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 10-29-48

Post mort Room

Medical Examiners Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 ✓ Registered No. 668

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 E. MADISON, (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL HARROD

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	

6 (b) Name of husband or wife / 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1883

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Harrod
13. Birthplace ?

MOTHER
14. Maiden Name Jinnie ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 3, 48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md
18 (a) Funeral director Chas O. Wilson
(b) Address 1000 Brantley ave

19 NOV 3 1948 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150 To be approved by Medical Examiner

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death: Arteriosclerotic

Due to: Heart

Due to: disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation CERTIFICATION APPROVED BY

Major findings of operation Robt. B. McFadden, M. D.

per

of autopsy: CHIEF DEPUTY MEDICAL EXAMINER

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas N P Johns
Address Johns Hopkins Hosp Date signed 11/3/48 M. D.

Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

ES-124164

Registered No. 1683

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 S. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Culler

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife ---

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 89 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Geo.

FATHER 13. Birthplace Balto. Md.

MOTHER 14. Maiden Name ?

MOTHER 15. Birthplace ?.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3/48 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herring Sons
(b) Address 2024 Orleans St.

19 (Date rec'd by Registrar) NOV 3 1948 (b) Huntington Williams, M.D. Registrar

TO BE APPROVED BY MEDICAL EXAMINER.

MEDICAL CERTIFICATION A

20. DATE OF DEATH 11-1 1948, at 10:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1948 to 11-1 1948, and that I last saw her alive on 11-1 1948

Immediate cause of death undetermined (?) — Duration

Due to ot. fell on 10/29/48 and sustained a Contusion

Duration ? wk. for Last.

Other Conditions Senility. A.J.C.V.D.
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation CERTIFICATION APPROVED BY

of autopsy: M. D.
CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: (Also state fully on back.)
(a) Accident, suicide or homicide
(b) Date of occurrence 10/29/48 at 8 PM
(c) Where did injury occur? Baltimore Balto. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury fell down stairs (unsafe)

23. Signature E. Munch M. D.
Address Balto. City Hosp. Date signed 11/2/48

8-2334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 e ✓

Registered No. 668234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Kolabird Camp (If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Swallow Circle (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Frank Jones

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: male | 5. Color or race: negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3-1-91

8. AGE: Years 57 | Months 8 | Days 1 | If less than one day: hr. ..... min.

9. Birthplace So. Carolina (Town, county, and state)

10. Usual Occupation W. P. A.

11. Industry or business .....

FATHER
12. Name Fred Jones
13. Birthplace So. Carolina

MOTHER
14. Maiden Name Sarah Foster
15. Birthplace So. Carolina

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Preastman St

19 NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1948, at 8 M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/9 1948 to 11/2 1948, and that I last saw h alive on 11/2 1948.

Immediate cause of death: Cachexia — Duration .....

Due to Carcinometosis

Due to Carcinome of transverse Colon

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation 10/11/48

Major findings of operation: Carcinoma of colon and carcinomatosis

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Richard T. Hayden, Jr. M.D.
Address Johns Hopkins Hosp (Date signed) 11/3/48

VS 199

668235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 668 [illegible] 8

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1322 Smithson St
(c) Hospital or institution: 16 or

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 Smithson St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Thomas Lee

3 (b) If veteran, name war —
3 (c) Social Security Account No. 223-20-1586

4. Sex	5. Color or race	6 (a) Single, married, (widowed), or divorced
Male	colored	

6 (b) Name of husband or wife Celina Lee
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 14 1879

8. AGE: Years	Months	Days	If less than one day
69	8	18	hr. ... min.

9. Birthplace Northumberland Co. Va (Town, county, and state)
10. Usual Occupation Fisherman
11. Industry or business

FATHER
12. Name James Lee
13. Birthplace Va

MOTHER
14. Maiden Name Emily Sidney
15. Birthplace Va

16 (a) Informant Linda D. Bea
(b) Address 1322 Smithson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/48 (mo.) (day) (year)
(c) Cemetery or crematory Lillian
Location Lillian

18 (a) Funeral director Geo. S. Nelson
(b) Address 1303 Pressman St

NOV 3 1948 (Date rec'd by registrar) (b) Washington Nelson Mill

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2-1948, at 2:PM

21. I certify that death occurred on the date above stated, that I attended deceased from 10-18-1948, to 11-2-1948, and that I last saw him alive on 11-2-1948

Immediate cause of death: Cerebral hemorrhage — Duration: 1 day

Due to (b) Hypertension & arterio Sclerosis — Duration: unknown

Due to — Duration:

Other Conditions Diabetes mellitus — Duration: unknown

(Include pregnancy within 3 months of death.)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 11-2-48

83a

68236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164C

Registered No. G68236

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Roland Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NATHANIEL BARZALLAI HODSKINS

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Elizabeth Hodskin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 2, 1918

8. AGE: Years 30 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace: Chicago, Ill. (Town, county, and state)

10. Usual Occupation: U. S. Postal Employee

11. Industry or business

FATHER
12. Name: Nathaniel B. Hodskin
13. Birthplace: Caton, N. Y.

MOTHER
14. Maiden Name: Anna M. Walker
15. Birthplace: Catonsville, Maryland

16 (a) Informant: Mrs. Mary E. Hodskin (wife)
(b) Address: 1006 Roland Hgts. Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: Balto., Md.

19 (a) NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1948, at 12:45 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/1/48 at approx. 12:05 A.M.
(b) Where did injury occur? Above Address
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: Firearms

23. Signature: [signature] Medical Examiner. M.D.
Date signed 11/1/48

VS 151

68237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 68237

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2211 W. Rogers Ave.

(c) Hospital or institution: Home for the Aged of the Meth. Ch.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2211 W. Rogers Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ADA BLANCHE HAMILTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Sherwood Hamilton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1877

8. AGE: Years	Months	Days	If less than one day
71	7	13	hr. min.

9. Birthplace Friendship, A. A. Co., Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name John Vinton Leitch

13. Birthplace Friendship, A. A. Co., Md.

MOTHER

14. Maiden Name Ella D. Howard

15. Birthplace Friendship, A. A. Co., Md.

16 (a) Informant Home for the Aged of the Meth. Ch.

(b) Address 2211 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1948, at 11:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1948 to Nov 1 1948 and that I last saw h[illegible] alive on Nov 1 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	10 days
Due to Arteriosclerosis	2yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Arthur G. Danes M. D.

Address 800 W 33rd St Date signed 11-2-48

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 159

68238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 468 Registered No. 468

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Miami
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 W. Riva Alto Drive
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Fingles

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: male | Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Susanna C. Fingles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-7-66

8. AGE: Years 82 | Months 4 | Days 24 | If less than one day: hr. min.

9. Birthplace N. Y. (Buffalo)
(Town, county, and state)

10. Usual Occupation Contractor retired

11. Industry or business

MOTHER | FATHER

12. Name Thomas Fingles

13. Birthplace Scotland

MOTHER

14. Maiden Name Mary ?

15. Birthplace Ireland

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem.

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1948, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26 1948, to 11-1 1948, and that I last saw him alive on 11-1 1948.

Immediate cause of death (1) Probable cerebral hemorrhage, due to (1)

Due to (2) Coronary Arteriosclerosis

(3) Diabetes mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman E Shaw M. D.

Address Johns Hopkins Hospital Date signed 11-2-48

VS 150

68239

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 63 L

Registered No. 68239

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4515 Garrison Blvd.
(c) Hospital or institution: Haven Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. 6409 Kriel Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME WALTER M. PLOWMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife: Sarah Louise Plowman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18 1872

8. AGE: Years 75 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace: Unknown (Town, county and state)
10. Usual Occupation: accountant
11. Industry or business: genral book-keeping

FATHER
12. Name: Joseph Plowman
13. Birthplace: Unknown

MOTHER
14. Maiden Name: ? Hess
15. Birthplace: Harford Co Maryland

16 (a) Informant: Walter M. Plowman
(b) Address: deceased.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1948 at 6.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1948 to Nov 2 1948 and that I last saw him alive on Nov 1 1948.

Immediate cause of death	Duration
Cerebral Thrombosis	5 days
Due to Generalized Atherosclerosis	?
Due to Senility	
Other Conditions Senile Dementia	3 mos.

(Include pregnancy within 3 months of death)

Date of operation none.
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joshua Harmacost M.D. M. D.
Address 6419 Windsor Mill Road Baltimore 7 Md. Date signed Nov 2 1948

VS 150

68240

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered Number 1688

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 S. Dallas Court
(c) Hospital or institution: 3-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 S. Dallas Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary V. Fulkerson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Mack

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1901

8. AGE: Years 46 | Months 10 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Washington, D. C.
(City, county, and state)

10. Usual Occupation Housewife

11. Industry or business ---

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mack Fulkerson
(b) Address 208 S. Dallas Court

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Nov. 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Mem'l Park Co
Location Balto. Co. Md.

18 (a) Funeral director B. M. Walters
(b) Address Baltimore, Md.

NOV 3 1948 (Date rec'd by Registrar) (b) NOV 3 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Nov. 1948 at 10 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. A. Kammerer, M.D.
Medical Examiner.
Date signed 2 Nov. 48

VS 151

68241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 Registered Number 16[illegible]

Please write plainly. The causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 427 S. Parrish St
(c) Hospital or institution: 19 C3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 S. Parrish St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY PRUSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife FELIKS PRUSKI

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 1- 1891

8. AGE: Years 57 | Months 6 | Days 1 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name PAUL JANICKI

13. Birthplace Poland

MOTHER 14. Maiden Name BERNICE WARDSKI

15. Birthplace Poland

16 (a) Informant FELIKS PRUSKI

(b) Address 427 S. PARRISH St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 5-1948 (month) (day) (year)

(c) Cemetery or crematory NEW CATHEDRAL

Location Balto Md

18 (a) Funeral director Cy B. M. Walters

(b) Address PRATT & STRICKER Sts

19. (a) Date rec'd by registrar NOV 3 1948 (b) Registration District Baltimore, Md

Registrar

NOV 3 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1948 at 12 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1948 to Nov 1, 1948 and that I last saw her alive on Nov 1, 1948

	Duration
Immediate cause of death Coronary Infarct	2 days
Due to Coronary Thrombosis	2 days
Due to Hypertensive Cardiovascular Disease	several yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abram Goldman M. D.

Address 206 S. Gilmor St Date signed Nov. 2, 48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 46 GCR 42

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 45
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 63

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Millrace Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Alberta Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-21-85

8. AGE: Years	Months	Days	If less than one day
63	1	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John McLean Martin
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Julia Anne Jones
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Hazel Lohr
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3, 1948 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Hagerstown

18 (a) Funeral director Paul C. Schumacher Jr.
(b) Address 5655 Belmont Ave

19 NOV 3 1948 (Date rec'd by registrar) (b) Huntington for Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 November 1948 at 2 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17, 1948 to 11-1 1948 and that I last saw her alive on 10-31, 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Carcinoma Gall Bladder	
Due to	
Other Conditions Metastases to liver, colon, mesentery. (Include pregnancy within 3 months of death)	

Date of operation 9-21-48
Major findings of operation: Widespread tumor Growth.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury James McC. Finney

23. Signature
Address Union Memorial Hospital Date signed 11-1-48 M. D.

VS 153

68243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 124a

Registered No. 668[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 78 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Baltimore, 14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 7804 Harford Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Clarke Kilchenstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wid.

6 (b) Name of husband or wife Adelaide
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/5/70

8. AGE: Years	Months	Days	If less than one day
78	0	28	hr. min.

9. Birthplace Baltimore (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Adam Kilchenstein
13. Birthplace Germany

MOTHER
14. Maiden Name Mary M.
15. Birthplace Germany

16 (a) Informant James Kilchenstein
(b) Address 7804 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director Lueck
(b) Address 5305 Harford Rd.

19 (a) NOV 3 1948 (Date rec'd by Registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1948 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/31/48 19..., to 11/2 1948 and that I last saw him alive on 11/2 1948

Immediate cause of death: Bronchopneumonia — Duration 1 day
Due to: Cirrhosis of Liver (Laennec's type)
Due to: Peptic Ulcer
Other Conditions: Generalized Arteriosclerosis

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Ray E. Brown Jr. M.D.
Address St. Joseph's Hosp. Date signed 11/2/48

VS 150

068244

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

932 ✓ Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2828 Lake Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2828 Lake Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY C. LOVELESS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Benjamin O.
6 (c) If alive, give age years.

7. Birth date of deceased (mo., day, yr) Feb. 16, 1875

8. AGE: Years	Months	Days	If less than one day
73	8	18	hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George Frey
13. Birthplace ?

MOTHER
14. Maiden Name Hannah ?
15. Birthplace ?

16 (a) Informant Mrs. Hilda Plowman
(b) Address 2828 Lake Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-48 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 NOV 3 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mon. 3 1948, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1948. to Nov. 3, 1948, and that I last saw h[illegible] alive on Mon. 3 1948.

Immediate cause of death — **Duration**

Pulmonary Edema — 1 hour
Due to Cardio - vascular hypertensive Disease — 12 years
Due to Arteriosclerosis — 12 years

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Richard J. Dausch M.D.
Address 1 W. Overlea Ave. Date signed 11 3 48

68845 Cordy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3111 Rosalie Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 Rosalie Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Teresa M. Heusler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife John H. Heusler, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1903

8. AGE: Years	Months	Days	If less than one day: hr.	min
45	1	19		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Conrad C. Frank
13. Birthplace Germany

MOTHER
14. Maiden Name Kunigunda Leoffler
15. Birthplace Germany

16 (a) Informant Mr. John Heusler
(b) Address 3111 Rosalie Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 NOV 3 1948 (Date rec'd by registrar) (b) Kensington Williams, M.D. Registrar

VS :50

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1948 at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1947 to Nov 1 1948.
and that I last saw her alive on Oct 31 1948.

Immediate cause of death: Coronary Occlusion — Duration: 4 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury None

23. Signature C. C. Gray M.D.
Address 5706 Harford Rd. Date signed 11-1-48

38246

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 68246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 01
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1358 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Naomi Alexander

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-5-08

8. AGE: Years	Months	Days	If less than one day
40	9	7	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Orphens Alexander
13. Birthplace Texas

MOTHER
14. Maiden Name Elizabeth Marshall
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cmty
Location Brooklyn Md Baltimore Md

18 (a) Funeral director Gudge P.A. Gibson Sr
(b) Address 1735 Druid Hill Ave

19 (a) NOV 3 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1948, at 3 38 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-31 1948, to 11-1 1948, and that I last saw her alive on 11-1 1948

Immediate cause of death Uremia

Duration

Due to Carcinoma of Cervix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Ward M. D.
Address Johns Hopkins Hosp. Date signed Nov 1

VS 153

G68247

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

135a

G68247 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Francis Scott Key
(c) Hospital or institution:
Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Hayward Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin M Kraft

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-6848

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Virginia Easter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3/28/1911

8. AGE: Years	Months	Days	If less than one day
37	7	5	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation unknown
11. Industry or business unknown

FATHER
12. Name Adam Edwin Kraft
13. Birthplace unknown

MOTHER
14. Maiden Name Anna May Martin
15. Birthplace Virginia

16 (a) Informant Mrs. W. Ryan
(b) Address Westminster Md

17 (a) Burial (b) Date thereof Nov 5 '48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Easter's
Location Westminster, Md

18 (a) Funeral director A. S. Harry & Sons
(b) Address Westminster, Md

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3 1948 at 2 0 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1948 to 11-3 1948 and that I last saw him alive on 11-3 1948

Immediate cause of death
Respiratory failure
Cardiac failure
Due to Acute infectious hepatitis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard E. Hall M. D.
Address Univ. Hosp. Date signed 11-3-48

668248

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668248 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division
(c) Hospital or institution: Provident Hospital 17 03
(d) Length of stay in hospital or inst. (yrs., mos., or days) day
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 734 W Mulberry (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Lizzie Foster
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Laure Foster
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) December 25, 1901
8. AGE: Years 46 | Months 10 | Days | If less than one day: hr. min.
9. Birthplace Blackstock, S.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Lewis Harrison.
13. Birthplace Blackstock, S.C.

MOTHER
14. Maiden Name Busty
15. Birthplace Blackstock S.C.

16 (a) Informant Isaac Harrison
(b) Address 1226 East Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-1948 (month) (day) (year)
(c) Cemetery or crematory Kingstree S. C.
Location S. C.

18 (a) Funeral director Mrs Katie A. Williams
(b) Address 322 N Schroeder St.

19 (a) (Name of Registrar) (b) Registrar

Form 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30- 1948, at 2 30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-24 1948, to 10-30 1948, and that I last saw her alive on 10-30 1948.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death.)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Forest Dept Date signed 11-2-48

Kingstree Williamsburg, S.C.

G68249 ✓ G68249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 W. Saratoga Street
(c) Hospital or institution: 1801

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Unk.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 W. Saratoga Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Webster Neal

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Laura Neal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1888

8. AGE: Years	Months	Days	If less than one day
60	9	5	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name Webster Neal
13. Birthplace Virginia

MOTHER
14. Maiden Name Laura ?
15. Birthplace Virginia

16 (a) Informant James H. Matthews
(b) Address 1338 Carroll Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Kate Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** October 30th 1948, at 10:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/11 1948 to 10/30 1948 and that I last saw h alive on 10/25 1948

Immediate cause of death: Chronic Cardio-Vascular Renal Disease — Duration: 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 600 N. Arlington Ave. Date signed 10-31-48

VS 150

G68250

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 8 3a

G68250
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 632 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EVA CUNNINGHAM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1917

8. AGE: Years	Months	Days	If less than one day: hr.	min.
31				

9. Birthplace Savannah, Ga. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Ben Hawkins
13. Birthplace Ga.

MOTHER
14. Maiden Name Carrie Mechel
15. Birthplace Ga.

16 (a) Informant: C lara Smith
(b) Address 230 Linn West St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5-1948 (month)

(c) Cemetery or crematory
Location Washington D. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bdantley ave

NOV 3 1948 (Date rec'd by registrar)

(b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nove. 2, 1948 at 6:45AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within ... months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D.
Medical Examiner.

Date signed 11. 2/48

X

G68251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G68251
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3-0 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH POLUMBO

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-9022

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mary Polumbo
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1884

8. AGE:

Years	Months	Days	If less than one day
64	11	28	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Stonemason

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Mary Polumbo
(b) Address 1130 Harford Avenue

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Nov. 4, 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Wendell Dippel
(b) Address 312 S. Highland Ave.

19 (c) 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1948, at 2:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: ~~natural causes~~ X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intestinal obstruction
Arteriosclerotic cardiovascular disease
~~Due to~~

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11-1-48

VS 151

G68252

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51 K G68252 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 Englewood Road
(c) Hospital or institution: 27-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4 Englewood Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Carter Brogden

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen Inglehart Brogden
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) May 24, 1871

8. AGE: Years	Months	Days	If less than one day
77	5	9	hr. min.

9. Birthplace Long Green, Balto. County, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James McCulloh Brogden
13. Birthplace Roedown, Anne Arundel County, Md.

MOTHER
14. Maiden Name Eleanor Addison Pettingall
15. Birthplace Long Green, Balto County, Md.

16 (a) Informant Lucille J. Brogden
(b) Address Hopkins Apts. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4 1948 (month) (day) (year)
(c) Cemetery or crematory Trinity Churchyard
Location Long Green, Balto. County, Md.

18 (a) Funeral director Henry W. Jenkins & Sons Co
(b) Address York Rd & Rossiter Ave

(Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1948, at 6:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 14 1941 to Nov. 2 1948, and that I last saw h(im) alive on Nov 2 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days
Due to: Arteriosclerosis
Due to:
Other Conditions: Carcinoma, prostate
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W Cannon M. D.
Address 1109 St. Paul St Date signed 11-3-48

820

668253
ES-123543

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668253
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTO. CITY HOSPITALS 26-09
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3422 O'Donnell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Spangler

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 9, 1877

8. AGE: Years	Months	Days	If less than one day
71	8	21	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Adam Reiter
13. Birthplace Md.

MOTHER
14. Maiden Name Rosie Dunigan
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5-48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Leeman Hill Rd.

18 (a) Funeral director John J. Connelly
(b) Address 41 E Eastern Ave. Essex Md.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH 11-2 1948 at 8:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1948 to 11-1 1948 and that I last saw her alive on 11-2 1948

Immediate cause of death	Duration
Heart failure	
Due to Arteriosclerotic heart disease & chronic failure	
Due to	
Other Conditions cirrhosis of liver	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David L. Marine M. D.
Address Balto Cy Hosps Date signed 11-2-48

93d

BALTIMORE CITY HEALTH DEPARTMENT 94a Registered No. 668254

CERTIFICATE OF DEATH

668254

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24-04
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Webster St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME GEORGE E. NEVAKER

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Sophia E.
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 12, 1893

8. AGE: Years	Months	Days	If less than one day
55	3	20	..... hr. ..... min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Enginer
11. Industry or business B. & O. R.R.

FATHER
12. Name Peter Nevaker
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Ditzel
15. Birthplace 1242 Carroll St.

16 (a) Informant Sophia E.
(b) Address 1242 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/48 (month, day, year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Mrs. Mrs. John W. Teufel & Son
(b) Address 5311 Edmondson Ave

19 (a) NOV 3 1948 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1948, at 4:30 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery Disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature George E. Merrill M.D. (Medical Examiner.)
Date signed 11/2/48

VS 151

68255

C-48-23542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59 Registered No. 68255

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette St.
(c) Hospital or institution: 21-07
Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1262 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Thompson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 25, 1948

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation enfant

11. Industry or business

FATHER — 12. Name Orus William Thompson

13. Birthplace Clay Co., Ky.

MOTHER — 14. Maiden Name Dorothy Mae House

15. Birthplace Corbette, Ky

16 (a) Informant Dorothy Thompson (mother)

(b) Address 1262 Washington Blvd. Balto Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo OCT 27 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) NOV 3 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26/ 1948, at 7 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5 1948 to 10/26 1948, and that I last saw her alive on 10/26 1948.

Immediate cause of death: a telectasis — Duration: 1

Due to: prematurity

Due to:

Other Conditions: 4
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Victor K. Spelsberg M. D.

Address 1 Franklin Square Date signed 10/27/48

VS 150

8256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

XV 668256

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. ..... (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME JAMES ROUTZAHN

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) .....

8. AGE: Years	Months	Days	If less than one day
	2		..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business .....

FATHER
12. Name U
13. Birthplace N

MOTHER
14. Maiden Name K N
15. Birthplace O

16 (a) Informant W N
(b) Address .....

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory .....
Location University Medical School OCT 27 1948

18 (a) Funeral director Commissioner of Health
(b) Address .....

19 (a) NOV 3 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1948, at 8.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Congenital atelectasis

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Emil Rogan M.D.
Medical Examiner

Date signed October 11, 1948

VS 151

66857 BALTIMORE CITY HEALTH DEPARTMENT 66857
CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 W. 2nd Ave Brooklyn (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Bayne
3 (b) If veteran, name war: U.S. Navy Enlistee
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Sep.
6 (b) Name of ~~husband~~ wife: Gladys Edwards
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr): 2-13-05
8. AGE: Years 43 | Months 8 | Days 19 | If less than one day hr. min.
9. Birthplace: Pa. (Town, county, and state)
10. Usual Occupation: Clerk (Civilian)
11. Industry or business: U.S. Maritime Comm.
FATHER 12. Name: Samuel E. Bayne
13. Birthplace: Md
MOTHER 14. Maiden Name: Fannie James
15. Birthplace: Md
16 (a) Informant
(b) Address: JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3, 1948 (month) (day) (year)
(c) Cemetery or crematory: Prospect Hill Cem.
Location: Towson, Mary Md
18 (a) Funeral director: John Burns' Sons
(b) Address: Towson, Md.
19 (a) (Date rec'd by registrar) (b) (Registrar's signature)
NOV 3 1948

MEDICAL CERTIFICATION
20. DATE OF DEATH Nov 2 1948, at 8 50 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1948 to Nov 2 1948, and that I last saw h~~im~~ alive on Nov 2 1948.
Immediate cause of death: Myocardial infarction — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. S. Holmes M. D.
Address Johns Hopkins Date signed 11/2/48

8-7899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66843

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 1803
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1235 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HERBERT A. RUNKLES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Seperated

6 (b) Name of husband or wife: Josephine Runkles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1881

8. AGE: Years 67 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Frederick Co., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph H. Runkles
13. Birthplace Md.

MOTHER
14. Maiden Name Emily Cashour
15. Birthplace Md.

16 (a) Informant: Mr. Frank Gardner
(b) Address Mt. Airy, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1948 (month) (day)
(c) Cemetery or crematory Prospect Cemetery
Location Frederick Co., Md.

18 (a) Funeral director E. M. Waltz
(b) Address Emmitsburg, Md.

19 (a) NOV 4 1948 (Date received by registrar) (b) Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1948, at 12:10 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature M.D. (Medical Examiner)

Date signed 11/3/48

VS 151

668259

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1 x 8

668259 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County Glen Rogers
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ira W. Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 1-21-87

8. AGE: Years 61 | Months 9 | Days 12 | If less than one day: hr. min.

9. Birthplace W. Va (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER 12. Name Albert Davis
13. Birthplace Va

MOTHER 14. Maiden Name Laura Cook
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/4/48 (month) (day) (year)
(c) Cemetery or crematory Sunset Mem. Cem
Location Beckley W. Va.
Tum Cook Inc

18 (a) Funeral director
(b) Address 217 St Paul st

19 (a) (Date received by registrar) NOV 4 1948 (b) Huntington W. Va. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3. 1948 at 3 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-29 1948, to 11-3-1948 and that I last saw him alive on 11-3-1948.

Immediate cause of death: Suppurative Pancreatitis — Duration: 9 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct 5, 1948.

Major findings of operation: Peri-pancreatic abscess; Oct 22 - Exploration of ~~surgery~~ under diaphragm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature x Handyman
Address The Johns Hopkins Hosp. Signed 11.3.48 M. D.

G68260

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68260 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME VIOLET L RISTON

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	None	Female	White	Married

6 (b) Name of husband or wife Franklin B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 8, 1896

8. AGE: Years	Months	Days	If less than one day: hr.	min.
52	2	25		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Will Fox
13. Birthplace Unknown

MOTHER
14. Maiden Name Ada (Unknown)
15. Birthplace Baltimore, Md.

16 (a) Informant Boris R. Durrett
(b) Address JOHNS HOPKINS HOSPITAL Chilesburg, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 4 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1948, at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1948, to Nov. 1948, and that I last saw her alive on Nov. 1948

Immediate cause of death	Duration
Due to Glioblastoma, right temporal lobe	6 mos +
Due to	
Other Conditions Cholecystitis chronic	

(Include pregnancy within 3 months of death)

Date of operation May 1948.
Major findings of operation: Glioblastoma (Craniotomy)
of autopsy: 3 Nov. 1948

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature (Wm. P. Thalhimer Jr.) M. D.
Address Date signed

VS 190

668261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 93d (668261)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5215 Eleanora Ave.
(c) Hospital or institution: 28 01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 5215 Eleanora Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH C. ANDERS

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Ellsworth M.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 19, 1863

8. AGE: Years: 85 | Months: 5 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Daisy A. Kirk
(b) Address: 5215 Eleanora Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: William Cook, Inc.
(b) Address: 1217 St. Paul St.

19 (a) NOV 4 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 3 1948, at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Nov. 3 1948 and that I last saw h alive on Nov. 2 1948

Immediate cause of death: Congestive Heart Failure

Due to: Cerebral Hemorrhage

Due to: Myocardial Degeneration

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)
(Specify type of place)
(e) Means of injury

23. Signature: H. J. Ramsett, M.D.
Address 1623 E. North Ave. Date signed 11/3/48

VS 199

668262

BALTIMORE CITY HEALTH DEPARTMENT ✓ 668262 Registered No.

CERTIFICATE OF DEATH 836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale 7717
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Konda

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 80 | Months: 8 | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Lithuania

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant: Jacob Teetelman
(b) Address: 1936 Webb Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-48 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Mt Carmel
Location:

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2400 Guilford Place

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1948, at 11 15 a.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1948 to 11-3 1948 and that I last saw her alive on 11-3 1948.

	Duration
Immediate cause of death: Cerebral thrombosis	
Due to: General arteriosclerosis	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Jerome J. Blumberg M. D.
Address Levindale Home Date signed 11-3-48

VS 150

68263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 ✓ Registered No. 668263

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2719 Biddle St Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY PAWLIK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Joseph (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1895

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Skilonez
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Marie Mozelbas
(b) Address 2709 Llewelyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cemetery
Location German Hill Rd

18 (a) Funeral director John J. Degen
(b) Address 2829 Hudson St.

19 NOV 4 1948 (Date rec'd by Registrar) Huntington Wilmuse M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3/1948, at 3 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18/1948 to 11/3/1948 and that I last saw h alive on 11/3/1948

Immediate cause of death	Duration
Cerebral Embolism	
Due to Arteriosclerotic Heart Dis.	
Due to	
Other conditions Coronary Occlusion Recent	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Fobter M.D.
Address Sinai Hospital Date signed 11/2/48 M D

VS 150

68264

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

X ✓ 668264 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d + Calvert Sts.
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day + ½ hr
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED: HARFORD
(a) State Md. (b) County Balto.
(c) City or town Bel Air, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Curtis Roe

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife — ?

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 1-4-85

8. AGE: Years 63 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Md. Pa. & Pa. Railroad

11. Industry or business

FATHER
12. Name William Roe
13. Birthplace New York

MOTHER
14. Maiden Name Isabelle Curry
15. Birthplace Maryland

16 (a) Informant Mrs Mary R Holloway
(b) Address Bel Air, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6/48 (month) (day) (year)
(c) Cemetery or crematory Deer Creek
Location Chestnut Hill Harford Co., Md

18 (a) Funeral director Joseph T Foster
(b) Address Bel Air Md

19 (a) NOV 4 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3 1948, at 3:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1948, to 11-3 1948, and that I last saw him alive on 11-3 1948

Immediate cause of death Coronary Occlusion, acute — Duration

Due to Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No abnormalities

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III
Address Union Memorial Hosp Date signed 11/3/48.

VS 150

G68265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 ✓

Registered No. G68265

GM. 124224

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals. 16-C
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 Bentalou ST. Z 16
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joan Bennett

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	D

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22- 1906

8. AGE: Years	Months	Days	If less than one day
42	6	11	hr min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph (D)
13. Birthplace Poland

MOTHER
14. Maiden Name Barbara ?(D)
15. Birthplace Poland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof nov 6 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry A. Ohnmacht
(b) Address 1004 Ridgewood Ave

19 (a) NOV 5 1948 (Date rec'd by registrar) Huntington Williams, M.D. REGISTRAR
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 2- 1948, at 11.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11- 1 - 1948 to 11- 2- 1948, and that I last saw her alive on 11- 2- 1948

Immediate cause of death	Duration
Carcinomatosis	
Due to Carcinoma of Left breast	4+ yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1945
Major findings of operation: Carcinoma of Left breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. W. Hornsby M. D.
Address Balto. City Hosp. Date signed 11/3/48

E. W. Hornsby

VS 150

68266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d ✓ Registered No. 68266

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 48.03
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 34 S. Carlton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME IDA DEAVER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife William Deaver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1873

8. AGE: Years	Months	Days	If less than one day
75	3	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Thomas Thompson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Unknown
15. Birthplace Baltimore, Md.

16 (a) Informant Edward J. McMahon
(b) Address 34 S. Carlton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month, day, year)
(c) Cemetery or crematory St. Peters
Location Baltimore

18 (a) Funeral director Frederick A. Dole
(b) Address 600 W. Lombard St
NOV 4 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

19. DATE OF DEATH Nov. 2 1948, at 6:20 A.M.

20. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner
Date signed 11/2/48

VS 151

68867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63 H

Registered No. 68867

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3500 Parkside Drive.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Parkside Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie) Mary) also Mamie E. Schaumburg

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry R. Schaumburg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 16, 1868

8. AGE: Years 79 | Months 11 | Days 17 | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Samuel Birckhead
13. Birthplace: Md.

MOTHER
14. Maiden Name: Elizabeth Swormstedt
15. Birthplace: Md.

16 (a) Informant: Mrs. Bessie Buttner
(b) Address: 710 McKewin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto. Md.

19 NOV 4 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1948; at 1 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 2/48 at approx. 7 P.M.
(b) Where did injury occur? 3500 Parkside Drive
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: burners on gas oven but unlit

23. Signature [signature] M.D.
Medical Examiner

Date signed 11/3/48

VS 151

668268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94a 68268

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 Sulgrave Avenue
(c) Hospital or institution: 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Sulgrave Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Wolfenden

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Eudora B. Wolfenden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 28, 1869

8. AGE: Years	Months	Days	If less than one day
78	11	4	hr. min.

9. Birthplace Baltimore Co., Maryland (Town, county, and state)
10. Usual Occupation Asst. Building Supt.
11. Industry or business Johns Hopkins University

FATHER
12. Name Thomas Wolfenden
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlotte Jones
15. Birthplace Maryland

16 (a) Informant Thomas H. Wolfenden
(b) Address 5717 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) [illegible] c'd by [illegible] Huntington Williams, M.D. Administrator

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH November 2, 1948, at 12.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1948, to Nov. 2 1948.
and that I last saw h[illegible] alive on Nov. 2 1948.

Immediate cause of death	Duration
Coronary Occlusion	2 hrs.
Due to arteriosclerosis	
Due to	
Other Conditions Congestive Heart Failure	3 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman Ward M. D.
Address 2601 Maryland Ave. Date signed 11/3/48

VS 150

G 66267
G68269 B.C.-48-2388

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59 ✓ Registered No. G68269

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 200 N. Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Pishnock

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-27-48

8. AGE: Years	Months	Days	If less than one day
		5-	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name John Pishnock
13. Birthplace Pa

MOTHER
14. Maiden Name Gertrude Reese
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Loft Dectod

18 (a) Funeral director
(b) Address Huntington Williams, Md.

19 NOV 4 1948 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1948. at 3 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1948 to Nov 1 1948. and that I last saw him alive on Nov 1 1948.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature C. C. Young M. D.
Address Johns Hopkins Hosp Date signed 11-2-48

VS 150

G68270 ✓ G68370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17-07
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Bunnan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Edward

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 2-7-95

8. AGE: Years	Months	Days	If less than one day
53	6	23	hr. min.

9. Birthplace Greenville, So Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Wilson
13. Birthplace ? S.C.

MOTHER
14. Maiden Name Marcie Johnson
15. Birthplace SC

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. Co. - Md.

18 (a) Funeral director Charles K. Law
Address 802 Mad. Ave.

19 (a) [illegible] (b) Huntington Williams, M.D.
Date rec'd by registrar [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1948 at 6 05 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-1 1948 to 11-1 1948 and that I last saw h[illegible] alive on 11-1 1948.

Immediate cause of death Hypoglycemia secondary to hyperinsulinism — Duration

Due to

Due to Cyst of pancreas, Pancreatic Adenocarcinoma, Metastasis to Liver, Carcinoma of Head of Pancreas, Complicated Pregnancy to Term

Other Conditions ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cyst of pancreas, Carcinoma of Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isabel Collen Harvey M. D.
Address Johns Hopkins Date signed 11-2-48

VS 150

1-28

668271

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 47

668271 Registered No.

1. PLACE OF DEATH: Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Menlo Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Manacher
3 (b) If veteran, name war none
3 (c) Social Security Account No. 212-03-9952

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Sadie Nee Zerwitz
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 26, 1901
8. AGE: Years 47 | Months 6 | Days 8 | If less than one day hr. min.
9. Birthplace New York City (Town, county, and state)
10. Usual Occupation
11. Industry or business Byer A. P. Tea Co

FATHER
12. Name Samuel Manacher
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Sadie Manacher
(b) Address 3501 Menlo Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 NOV 5 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/1948 at 10 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27/1948 to 11/4/1948. and that I last saw h[illegible] alive on 11/4/1948.

Immediate cause of death
Due to Metastatic C.A.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation 11/4/48
Major findings of operation: BRONCHOSCOPY STOMACH Bronchoscopy stomach
of autopsy: [illegible] gradual

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address Sinai Hospital Date signed 11/4/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 68272

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) //

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Coeburnville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Douglas Hearne

3 (b) If veteran, name war / | 3 (c) Social Security Account No.

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-8-47

8. AGE: Years 1 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Hearne
13. Birthplace Indiana

MOTHER 14. Maiden Name Miriam Hearne
15. Birthplace Pa

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory W. Laurel Hill
Location Philadelphia, Penna.

18 (a) Funeral director E. E. Tyson
(b) Address Reading, Pa.

19 (a) Filed by (Registrar) Huntingdon Williams, M.D. Registrar
(b) Huntingdon Williams, M.D.

VS 153

MEDICAL CERTIFICATION

250

20. DATE OF DEATH Nov. 3 1948, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1948, to 11/3 1948, and that I last saw him alive on 11/3 1948.

Immediate cause of death: Pulmonary edema — Duration
Due to Cardiac failure
Due to
Other Conditions Operation for transposition of the great Vessels
(Include pregnancy within 3 months of death)
Date of operation 11-1-48.
Major findings of operation: Transposition of the great Vessels
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Ryan M.D.
Address Johns Hopkins Hosp. Date signed 11-4-48
M. D.

68273

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH 163 M

Registered No. 68273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (Va.) Va. (b) County
(c) City or town (Herndon) Herndon
(If outside city or town limits, write RURAL and give town)
(d) Street No. (Route #3)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles (E.) JUDSON STODDARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mildred A.

6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1916

8. AGE: Years 31 Months 11 Days 2 If less than one day hr. min

9. Birthplace Washington, D.C. Silver Spring
(City, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Judson Stoddard

13. Birthplace Washington, D. C. DeGarmo

MOTHER 14. Maiden Name Caroline (DeGarmo)

15. Birthplace Washington, D. C.

16 (a) Informant Mrs. Mildred A. Stoddard

(b) Address 2926 Silver Hill Avenue

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Nov. 4, 1948 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director E. Willis Lamoreau

(b) Address 4510 Liberty Heights Ave.

19 (a) NOV 4 1948 (b) Date rec'd by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 15

20. DATE OF DEATH November 1, 1948 at 6: P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at ? M.
(b) Where did injury occur? Rear of -- 2510 Talbot Road
(c) Did injury occur at home, on farm, industrial place, or public place? Garage While at work? no
(d) Means of injury auto Closed garage - motor on

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11-2-48

VS 151

68274 ✓ 68274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5616 Stonington Avenue
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2 USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5616 Stonington Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND JOHN WILHIDE

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-6739

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lulu P. Wilhide
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) December 20, 1898

8. AGE: Years	Months	Days	If less than one day
49	10	13	hr. min.

9. Birthplace Walkersville, Md.
(Town, county, and state)
10. Usual Occupation Telephone Switchman
11. Industry or business C & P Telephone Co.

FATHER
12. Name John R. Wilhide
13. Birthplace Frederick County, Md.

MOTHER
14. Maiden Name Fannie Fitz
15. Birthplace Frederick County, Md.

16 (a) Informant Mrs. Lulu P. Wilhide
(b) Address 5616 Stonington Avenue

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Nov. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cemetery
Location nr. Keymar, Md.

18 (a) Funeral director E. WILLIS LA. OREAU
(b) Address 4510 Liberty Heights Avenue

19 NOV 4 1948 (Date rec'd by Registrar) **(b)** Huntington Woods, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1948 at 8 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ✓, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Unrelated fracture of right femur.
Cerebral edema
Due to Syphilitic aortitis.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-3-48 at ? M.
(b) Where did injury occur? Outside 5616 Stonington Avenue
(c) Did injury occur at home, on farm, industrial place, public place? outside home While at work? No
(d) Means of injury Fell from ladder

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 11/3/48

VS 151

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G68275

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

G68275 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5505 Wayne Ave.
(c) Hospital or institution: 2807
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5505 Wayne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jean Brown Macnab

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Helen M. Macnab
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1886

8. AGE: Years	Months	Days	If less than one day
62	5	24	hr. min.

9. Birthplace Scotland (Creiff)
(Town, county, and state)
10. Usual Occupation C. P. A.
11. Industry or business Self

MOTHER / FATHER
12. Name Archibald Macnab
13. Birthplace Scotland

MOTHER
14. Maiden Name Jean Brown
15. Birthplace Scotland

16 (a) Informant Mr. Robert Macnab
(b) Address 5505 Wayne Ave.

17 (a) Burial (b) Date thereof Nov. 5, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore, Md.

18 (a) Funeral director Willis Lamoreaux
(b) Address 1500 Liberty Heights Ave.

19 (a) NOV 4 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1948, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1948 to Nov. 3 1948, and that I last saw h alive on Nov. 3 1948.

	Duration
Immediate cause of death Pulmonary embolism	3 days
Due to Arteriosclerotic hypertension cardiovascular disease	5 yrs +
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 20 E. Preston St. Date signed Nov 4 48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 100

G68276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G68276

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ingram Hall Apts.
(c) Hospital or institution: 47-20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Ingram Hall Apts. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MARGUERITE BROWN BAER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Louis B. Baer.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1889.

8. AGE: Years	Months	Days	If less than one day
59	4	14	hr. min.

9. Birthplace Cincinnati, Ohio. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Daniel F. Brown,
13. Birthplace Cincinnati, Ohio.

MOTHER
14. Maiden Name Miriam Klopfer,
15. Birthplace Cincinnati, Ohio.

16 (a) Informant Mr. Louis B. Baer,
(b) Address Ingram Hall Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/48. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Baltimore, Md.

18 (a) Funeral director Burial Association of Baltimore
(b) Address 1902 Eutaw Place.

19 NOV 4 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2nd. 1948, at 11.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1948 to Nov 2 1948 and that I last saw h[illegible] alive on Nov 2 1948.

Immediate cause of death	Duration
Coronary occlusion	1 hr
Due to Coronary Sclerosis	1 year
Due to Generalized Arteriosclerosis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emmett R. Cregan, M.D.
Address Esplanade Apts. Date signed 11/3/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68277

BALTIMORE CITY HEALTH DEPARTMENT 93 2 ✓ G68277 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3323 Hudson St.
(c) Hospital or institution: 76-11.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3323 Hudson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward P. Blank.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Margaret D. Blank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-31-1877

8. AGE: Years	Months	Days	If less than one day
71	0	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Baltimore City Worker

FATHER 12. Name John B. Blank

13. Birthplace Ireland

MOTHER 14. Maiden Name Annie Blank

15. Birthplace Ireland.

16 (a) Informant Edward P. Blank Jr.

(b) Address 3323 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-48 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem.

Location Edmondson Ave.

18 (a) Funeral director Charles J. Feeley

(b) Address 904 S. Conkling St.

19 (a) NOV 9 1948 (b) Registered Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 – 2 – 1948 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1946 to Nov 2 1948 and that I last saw h[illegible] alive on Oct 31 1948.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Cardiac Decompensation	
Due to Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. A. Flanigan Jr. M.D.

Address 3503 Fait Ave. Date signed 11-3-48

VS 150

668278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Payson Ave & Dakeland St.
(c) Hospital or institution: West Baltimore General Hosp. 9-04
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Ensor St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick J. Dolan

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Julia Dolan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1895

8. AGE: Years	Months	Days	If less than one day
53 yrs	8 mos	28 da.	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Industrial Building Co.

FATHER
12. Name Michael Dolan
13. Birthplace Ireland

MOTHER
14. Maiden Name Duigan
15. Birthplace Ireland

16 (a) Informant Mrs Julia Dolan
(b) Address 1303 Ensor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director Eugene W. Conklin
(b) Address 924 E. Fayette St.

19 (a) NOV 4 1948 (date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4 1948, at 3 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1948, to 11/4 1948, and that I last saw h/m alive on 11/4 1948.

Immediate cause of death: Bleeding Esophageal varices
Due to: Portal Cirrhosis
Due to:
Other Conditions: Bilateral ind. inguinal hernia (Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Fleischer M. D.
Address Mt. Balto. Med. Hosp. Date signed Oct. 4, 1948

VS 150

Please type or print plainly. Physicians: please write the causes of death clearly and legibly.

G68279 X ✓ G68279

G68279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G68280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G68280

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2639 E. Madison Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2639 E. Madison Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ANGIOLINA MARIA SARAULLO

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Frank Saraullo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1893

8. AGE: Years	Months	Days	If less than one day
54 yrs.	11	2	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Rafaele Scagliarini
13. Birthplace Italy

MOTHER
14. Maiden Name Luigia Puluzzi
15. Birthplace Italy

16 (a) Informant Mr. Frank Saraullo – husband
(b) Address 2639 E. Madison Street

17 (a) Burial (b) Date thereof 11/5/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) [illegible] (b)
([illegible] by registrar) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1948, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1948 to Nov. 2 1948, and that I last saw h[illegible] alive on Nov 2 1948.

Immediate cause of death	Duration
Hypostatic Pneumonia	10/31/48
Due to Carcinoma of Rectum with Metastasis	1/1/48
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Rybarek M.D.
Address 801 Kenilworth Date signed 11/2/48

VS 150

RIMBACH

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G68281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reynor Ave + Dukeland St.
(c) Hospital or institution West Baltimore General No 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 142 Willard St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bertha Rimbach

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife George Rimbach

6 (c) If wife, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 28, 1864

8. AGE: Years 84 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Wiskow
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Alois Ernest Rimbach
(b) Address 142 Willard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Edmondson Ave. Washington Pl. Williamsport, Md.

19 (a) 5 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1948, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1948, to Nov. 3 1948, and that I last saw h[illegible] alive on Nov. 3 1948.

Immediate cause of death, Adenocarcinoma of pancreas with generalized abdominal carcinomatosis — Duration 6 mos.

Due to

Due to

Other Conditions Arteriosclerotic Cardiovascular Disease
(Include pregnancy within 3 months of death)

Date of operation Oct. 27, 1948

Major findings of operation: Same

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel L. Silverstein
Address West Balto Gen. Hosp. Date signed 11/3/48

VS 100

8282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a2

Registered No. 668282

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: BON SECOURS HOSPITAL 27-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE 15 Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5001 PARK Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MR. HARRY Odell FARLEY
3 (b) If veteran, name war
3 (c) Social Security Account No. 220-20-2298

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~.
M	W	

6 (b) Name of husband or wife MRS. Ida FARLEY
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Dec 17-1844

8. AGE: Years	Months	Days	If less than one day
58	10	17	hr. min.

9. Birthplace BALTIMORE Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name ? Farley
13. Birthplace Va.

MOTHER
14. Maiden Name Gertrude Justice
15. Birthplace Va

16 (a) Informant Mrs Ida C Farley
(b) Address 5001 Park Heights Ave

17 (a) Burial (b) Date thereof 11/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location

18 (a) Funeral director Wm. Cook Inc
(b) Address 1217 St Paul St at Huntington Williams, Md

19 (a) NOV 5 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/48 19 . at 11.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/48 19 . to 11/4/48 19 .
and that I last saw him alive on 11/4/48 19 .

Immediate cause of death Heart failure — Duration

Due to Coronary Thrombosis

Due to Peripheral vascular Collapse

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(Specify type of place)
(e) Means of injury

23. Signature William B. Wonach M D
Address BON SECOURS HOSP. Date signed 11/4/48

VS 150

8283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

XV G68283 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: HARFORD
(a) State Md. (b) County Co
(c) City or town Edgewood.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY THARP

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Donald.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) about 1906

8. AGE: Years 42 | Months | Days | If less than one day: hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Monroe Yordy
13. Birthplace Pa

MOTHER 14. Maiden Name Mary Zimmerman
15. Birthplace Pa.

16 (a) Informant Donald Tharp
(b) Address Edgewood Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/5/48 (month) (day) (year)
(c) Cemetery or crematory Sunbury
Location Wm Cook Inc

18 (a) Funeral director
(b) Address 217 St Paul St

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948, at 12 noon

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1948 to Nov. 5 1948 and that I last saw h alive on Nov. 5 1948.

Immediate cause of death Cardiac failure & respiratory failure — Duration

Due to anemia

Due to chronic vascular renal disease with hypertension

Other Conditions pulmonary atelectasis bronchopneumonia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A White M. D.
Address University Hosp. Date signed 11-5-48

VS-153

8284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

✓ 668284

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3-0 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 E. Lombard (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE THOMAS SKIPPER

22748

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE:	Years	Months	Days	If less than one day
	65			hr. min.

9. Birthplace UN KN (Town, county, and state)

10. Usual Occupation Unk

11. Industry or business

FATHER
12. Name U
13. Birthplace N K

MOTHER
14. Maiden Name N
15. Birthplace O W N

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 27 1948
Commissioner of Health

18 (a) Funeral director
(b) Address NOV 5 1948

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1948, at 10:20 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.
Date signed 10/11/48

VS 151

668285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

668285 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 N. Lakewood Ave
(c) Hospital or institution: 6-0

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 N. Lakewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanislawa Elizabeth Kaminsky

3 (b) If veteran, name war

3 (c) Social Security Account No 212 16 3636

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Wladyslaw

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
56	—	—	hr. min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Zamuski
13. Birthplace Poland

MOTHER
14. Maiden Name Wank
15. Birthplace Poland

16 (a) Informant Gregory Kaminski
(b) Address 124 N. Lakewood Ave

17 (a) Burial (b) Date thereof 11/6/48 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozog[illegible]
(b) Address 1930 Eastern Ave

19 [illegible] 5 1948 (b) Frontington Williams
(Signature of Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Nov. 1948, at 9:17 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammond, Jr. M.D.
Medical Examiner.
Date signed 3 Nov. 48

VS 151

8286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G68286

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2776 Shirley Ave

(c) Hospital or institution: Mt Carmel Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8

(e) Length of stay in Baltimore (yrs., mos., or days) √7 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1208 W Pratt St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosie Schmuckler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 71 | Months | Days 2 | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Not known

13. Birthplace Russia

MOTHER 14. Maiden Name Jennie

15. Birthplace (town, county, and state) Russia

16 (a) Informant Louis Schmuckler

(b) Address 3816 Towanda Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-5-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 2400 Eutaw Place

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 — 4 — 1948 at 7:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from June 30 1948 to Nov 4 1948 and that I last saw h[er] alive on Nov 4 1948

Immediate cause of death: Coronary Thrombosis — Duration: Instant

Due to: Arteriosclerosis & Cardiac Failure — 6 mo.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Benton M. Kalman M.D.

Address 3700 Park Heights Ave Date signed Nov 5 1948

VS 150

X

68287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓

Registered No. G68287

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 27-19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Narcissus Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Goldsmith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day hr.	min.
64				

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name not known
13. Birthplace Poland

MOTHER
14. Maiden Name not known
15. Birthplace Poland

16 (a) Informant Lena Goldsmith
(b) Address 800 Narcissus Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-48 (month) (day) (year)
(c) Cemetery or crematory
Location Herring Run

18 (a) Funeral director Jack Kerbo Inc
(b) Address 206 Eutaw Place

19 (a) (Signature) (b) Registrar for Baltimore City

NOV 5 1948

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948 at 4:10 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 1 1948 to Nov. 5 1948 and that I last saw h in alive on November 5 1948

Immediate cause of death Myocardial Infarction — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.M. Silverstein M. D.
Address Sinai Hospital Date signed 11-5

C.M. Silverstein

68288

ES-123775

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46E

Registered No. 68288

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTO. CITY HOSPITALS 7-03
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2017 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Rosenthal

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Wid.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 26, 1884

8. AGE: Years	Months	Days	If less than one day
64	3	5	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Dominick (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Shorhart (D)
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location Edmondson Ave & Hilton Road

18 (a) Funeral director J. J. Foley & Sons
(b) Address 218 Light St

19 NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31 1948 at 5:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1948 to 10-31 1948 and that I last saw her alive on 10-31 1948

Immediate cause of death Carcinoma

Due to adeno carcinoma of Colon

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 4-14-18-48 Biopsy

Major findings of operation: Carcinoma Rec

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Moriarty M. D.
Address Balto. City Hosp. Date signed 11/3/48

VS 150

G68289

ES-29423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G68289

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 EASTERN AVE.

(c) Hospital or institution: BALTO. CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Yrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 132 or 1328 Linden Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Merryman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John Albertus (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1871

8. AGE: Years	Months	Days	If less than one day
77	1	2	hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Augustus Shue (D)

13. Birthplace Norway

MOTHER

14. Maiden Name Matilda Johnson

15. Birthplace Norway

16 (a) Informant RECORDS--BALTO. CITY HOSPITALS

(b) Address 4940 EASTERN AVE.

17 (a) Burnie (Burial, cremation, or removal) (b) Date thereof 11/5/48 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Cem

Location Baltimore & Hill Road

18 (a) Funeral director J. J. Foley & Sons

(b) Address 318 Light St.

19 (a) Nov 5 1948 (b) Huntington Williams MD

Registered by (Signature and title)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1948, at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1937 to 10-30 1948, and that I last saw her alive on 10-30 1948.

Immediate cause of death Cerebral vascular accident & left hemiparesis — Duration 2 days

Due to Hypertensive arteriosclerotic cardiovascular disease

Due to

Other Conditions Bronchopneumonia — 2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature David H. Marine M. D.

Address Balto City Hosp Date signed 11-3-48

VS 153

X

Medical Examiner's Case
(Case Released To Hospital)

668290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

Registered No. 668290

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 752, Popular House St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herbert L. Schaaf Herbert Lunwood Schaaf

3 (b) If veteran, name war

3 (c) Social Security Account No. 227-16-4465

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Eunice Schaaf
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Sept 3 - 1889

8. AGE: Years	Months	Days	If less than one day
59	2	1	hr. min.

9. Birthplace Richmond Va (Town, county, and state)
10. Usual Occupation Repair man
11. Industry or business Hobby Shop

FATHER
12. Name John B. Schaaf
13. Birthplace Richmond Va

MOTHER
14. Maiden Name Julia Jordan
15. Birthplace U.S.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month) (day) (year)
(c) Cemetery or crematory Oakwood Cem
Location Richmond, Va.

18 (a) Funeral director E. Willis Lamoreau
(b) Address 4510 Liberty Heights

19 (a) NOV 5 1948 received by registrar, transcribed for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1948, at 6.35 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 1948 to 11-4 1948.
and that I last saw h alive on 11-4 1948.

Immediate cause of death Necrosis of almost all of small bowel

Duration

Due to ? embli, ? toxin

Due to

Other Conditions Arteriosclerosis & Hypertensive cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy: Enlarged left ventricle

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Jackson M.D.
Address The J. H. H. Date signed 11/5/48

VS 150

Medical Examiner's Case certificate to be Approved 123

68291 17 death

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. G68291

CERTIFICATE OF DEATH 46 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1125 N. Bond St
(c) Hospital or institution: 8-07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 N Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert H. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-6442

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Beatrice Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22-1898

8. AGE: Years 49 Months 10 Days 11 If less than one day hr. min.

9. Birthplace Saluda Co. S C (Town, county, and state)

10. Usual Occupation Sales

11. Industry or business

FATHER 12. Name Carroll Smith

FATHER 13. Birthplace Saluda Co. S C

MOTHER 14. Maiden Name Ida Wilson

MOTHER 15. Birthplace Saluda Co. S C

16 (a) Informant Beatrice Smith

(b) Address 1125 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6-1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park

Location Arbutus Md

18 (a) Funeral director Tofat L. Williams

(b) Address 1545 McElderry St

19 (a) [illegible] (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1948 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1948 to Nov 2 1948, and that I last saw him alive on Nov 2 1948.

Immediate cause of death: Carcinoma of Stomach with Pyloric Obstruction — Duration: 6 mos

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: No

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph J. Young M. D.

Address 1424 Monument St Date signed 11/4/48

VS 180

G68292

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G68292
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home 8 06
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1538 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAX HERMAN PAULUS

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	None	M	W	Married

6 (b) Name of husband or wife Caroline G. Paulus
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr) July 21, 1860

8. AGE: Years	Months	Days	If less than one day
88	3	14	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Plumbers Supply Co.

FATHER
12. Name Herman Paulus
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Baumgartner
15. Birthplace Germany

16 (a) Informant Mrs. Caroline C. Paulus
(b) Address 1538 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month) (day) (year)
(c) Cemetery or crematory Riverview Cemetery
Location Wilmington, Delaware

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) NOV 5 1948 (Date rec'd by registrar) Huntington Williams Jr. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 4 1948, at 2.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 1942 to Nov. 4 1948, and that I last saw h alive on Nov. 3 1948.

Immediate cause of death Coronary Occlusion — Duration 48 Hours
Due to Arteriosclerosis (Generalized)
Due to
Other Conditions Mental Deterioration — 10 years
Diabetes Cerebral Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W Brafton Hersperger
Address 214 Medical Arts Bldg Date signed 11/4/48 M. D.

VS 189

G68293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G68293

G68293

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 206 Wyndhurst Avenue
(c) Hospital or institution: 2711
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 73 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Wyndhurst Avenue (If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -------

3 (a) FULL NAME: James Francis McCabe, Jr.

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Leila Post
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) August 5, 1875

8. AGE: Years	Months	Days	If less than one day
73	2	29	-- hr. -- min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: ------

FATHER
12. Name: James F. McCabe
13. Birthplace: Havre De Grace, Md.

MOTHER
14. Maiden Name: Gertrude Knight
15. Birthplace: Cecil County, Md.

16 (a) Informant: Mrs. James F. McCabe, Jr.
(b) Address: 206 Wyndhurst Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month) (day) (year)
(c) Cemetery or crematory: St. Mary's
Location: Govans, Md.

18 (a) Funeral director: H. W. Means and Son
(b) Address: 805 N. Calvert Street

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4th 1948, at 5:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1948 to Nov. 5th 1948, and that I last saw him alive on Nov. 3rd 1948

Immediate cause of death: Coronary artery disease

Due to: Arteriosclerosis

Due to:

Other Conditions: Hemiplegia due to old injury.
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: ——

of autopsy: None

Duration: six months; several years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Edward E. Chatard M. D.
Address: 1300 N. Calvert St. Date signed 11-4-48

Remington for Allegheny, Md.

X

G68294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G68294

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 E. Mt. Vernon Place
(c) Hospital or institution: none 11-0

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 E. Mt. Vernon Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Priscilla Richardson Grafflin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Daniel A. Grafflin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 7, 1901

8. AGE: Years: 47 | Months: 8 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: James Thomas Richardson
13. Birthplace: Snow Hill, Maryland

MOTHER
14. Maiden Name: Margaret Bonneville
15. Birthplace: Snow Hill, Maryland

16 (a) Informant: Mrs. Lawrence Clark
(b) Address: 1701 Sulgrave Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/48 (month) (day) (year)
(c) Cemetery Druid Ridge
Location: Pikesville, Maryland

18 (a) Funeral director: John O. Mitchell & Sons, Inc.
(b) Address: 1900 Eutaw Place, Baltimore

NOV 5 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Apr. 1948 to 3 Nov. 1948 and that I last saw h[illegible] alive on 3 Nov. 1948

Immediate cause of death: Cancer of breast with multiple metastases — Duration: 3 yrs.

Due to:

Due to:

Other Conditions: Healed tuberculosis — Duration: 18 yrs.

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Louis E. Wice, M.D.
Address: 920 St. Paul St. Date signed: 5 Nov. '48

668295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

GM. 96452

Registered No. G68295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 Clairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife ALICE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 28- 1877

8. AGE: Years	Months	Days	If less than one day
71	5	4	hr. ; min.

9. Birthplace PA.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Samuel Johnson
13. Birthplace Wales

MOTHER
14. Maiden Name Mary Jones
15. Birthplace PA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 322 S. High St.

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11- 1 - 19 48 at 11.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10- 3- 19 45 to 11-1 - 19 48 and that I last saw him alive on 11-1- 1948

Immediate cause of death Cardiac failure — Duration

Due to arteriosclerotic heart disease

Due to

Other Conditions Pulmonary emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Warren
Address Balto. City Hosp. Date signed 11-9-48

VS 150

8296 BALTIMORE CITY HEALTH DEPARTMENT X V G68296

BC-48-22773 CERTIFICATE OF DEATH 159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lakeland & Raynor Ave
(c) Hospital or institution: West Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 2days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 435 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Higdon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 1 | If less than one day 3 6/12 hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Franklin Higdon
13. Birthplace Balto Md

MOTHER 14. Maiden Name Violet Marie Phelps
15. Birthplace Severn Md

16 (a) Informant Mrs Violet Higdon
(b) Address Box 435 Brooklyn 25 Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 3 1948 Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) NOV 5 1948 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28 1948 to 10/30 1948, and that I last saw h[illegible] alive on 10/30 1948.

Immediate cause of death	Duration
(a) Prematurity	
Due to (b) Atelectasis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy: Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman Levin MD
Address [redacted] Date signed 11/1/48

VS 150

68297

D. - 7726

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

927

Registered No. 68297

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home Address
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Will Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? ? 1884

8. AGE: Years	Months	Days	If less than one day
64 ?			hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Williams
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Faunke
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 5 1948

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 5 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26, 1948, at 11.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1942, to Oct. 26 1948, and that I last saw h im alive on Oct. 26 1948

Immediate cause of death Heart failure — Duration

Due to Arteriosclerotic heart disease

Due to

Other Conditions Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David A. Marine M. D.
Address Balto City Hosp Date signed 10-28-48

VS 150

68298

ES-123994

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 727

Registered No. 68298

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Brunk (Brunt) St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Parsons.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1905

8. AGE: Years	Months	Days	If less than one day
43	3	5	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Berrnett
13. Birthplace Md.

MOTHER
14. Maiden Name Mollie Dorsey
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 5 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23 19 48 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 19 48 to 10-23 19 48 and that I last saw her alive on 10-23 19 48

Immediate cause of death: Pul edema-myocardial failure — Duration

Due to

Due to

Other Conditions 2° anemia
Vit deficiency
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. T. Nelson
Address BCH Date signed 10-28 M. D.

VS 189

111c

668299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164 c.

668299 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 27-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Tyndale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM ALBERT POWELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Anna L. Powell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1917

8. AGE: Years	Months	Days	If less than one day
31	7	28	hr. min.

9. Birthplace Wilmington, Delaware (Town, county, and state)
10. Usual Occupation Photographer
11. Industry or business

FATHER
12. Name Hartley Powell
13. Birthplace New Jersey

MOTHER
14. Maiden Name Pearl Shoemaker
15. Birthplace Unknown

16 (a) Informant Mrs. Anna L. Powell
(b) Address 3211 Tyndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director Ullrich Funeral Home.
(b) Address 2008 Orleans St.

19 (a) [redacted] (Signature of Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nove. 4, 1948, at 7 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet Wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 3/48 at approx. 7 P.M.
(b) Where did injury occur? 3211 Tyndale Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Earl L. Ryan M.D. Medical Examiner.
Date signed 11/4/48

G68300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68300 Registered No. 27762

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 327 W. Biddle St.
(c) Hospital or institution: 11 03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 327 W. Biddle St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Lindsay Ayers

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Sarah Bewley Ayers
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Not known

8. AGE: Years	Months	Days	If less than one day
74?	?	?	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

PARENTS
12. Name Henry Ayers.
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Henry F. Ayers
(b) Address 327 W. Biddle St.

17 (a) Burial (b) Date thereof 11-7-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director Mrs Frances A. Hensley
(b) Address 548 W Biddle St

19 (a) NOV 5 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1948, at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1947 to 19 , and that I last saw him alive on Nov. 4 1948

Immediate cause of death: Cerebral Hemorrhage — Duration 1 day
Due to Arterio-sclerosis. — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work)
(e) Means of injury

23. Signature R B Eyestone M. D.
Address 501 Cherry Hill Rd. Date signed

VS 150

068301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. 068301

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1035 Bentley Ave
(c) Hospital or institution: 1035 Bentley Ave Heart
(d) Length of stay in hospital or institution: (yrs., mos., or days) 9 years
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 Bentley Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Violet Johns Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Widow

6 (b) Name of husband or wife Clarence Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-20-93

8. AGE: Years	Months	Days	If less than one day
55		14	hr. min.

9. Birthplace Eastern Shore (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Johns
13. Birthplace Unknown Eastern Shore?

MOTHER
14. Maiden Name Carrie Johns
15. Birthplace Unknown?

16 (a) Informant Edward Grafton Johns (SON)
(b) Address 1035 Bentley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St Huntington Williamsport, Md.

19 (a) Filed 1948 (b) (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1948, at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1948 to Nov 3 1948, and that I last saw h SR alive on Nov 2 1948.

Immediate cause of death	Duration
Hemorrhage	
Due to Carcinoma of Uterus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Russell M. D.
Address 301 Penna Ave Date signed Nov 3/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

68302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G68302 Registered No.

BS-123521 46B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 EASTERN AVE.

(c) Hospital or institution: BALTO. CITY HOSPITALS.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days.

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. Crownsville State Hospital (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Washington Neal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 18, 1880

8. AGE: Years	Months	Days	If less than one day
68	1	2	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Isaih ?

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Millie Thompson (D)

MOTHER 15. Birthplace Md.

16 (a) Informant RECORDS--BALTO. CITY HOSPITALS

(b) Address 4940 EASTERN AVE.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School NOV 5 1948

18 (a) Funeral director Commissioner of Health

(b) Address

NOV 5 1948 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20 1948 at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5- 1948 to 10-20 1948, and that I last saw h in alive on 10-20 1948.

Immediate cause of death ~~d.~~ Malnutrition — Duration Weeks

Due to Carcinoma of Stomach — ?

Due to.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 15/10/1948

Major findings of operation: Carcinoma of Stomach

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Norman Cole M.D. M. D.

Address 4940 Eastern Ave Date signed 10/28/48

VS 150

X

68303

ES-122584

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registration No. 68303

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS 14 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Owan Dougherty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1900

8. AGE: Years	Months	Days	If less than one day
47	10	26	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Pat Dougherty
13. Birthplace Mass.

MOTHER
14. Maiden Name Emma Woods
15. Birthplace W. Va.

16 (a) Informant RECORDS--BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 5 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Washington Hill, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21- 19 48 at 12:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31 19 48 to 10-21 19 48, and that I last saw him alive on 10-21 19 48

Immediate cause of death: Probable Coronary occlusion — Duration 2 days

Due to arteriosclerosis

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H Verlenden M.D.
Address Balto City Hosp Date signed 28 Oct 48

VS 193

94a

Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

668304 ✓ 668304 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3037 Guilford Ave
(c) Hospital or institution: 12-C ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 3037 Guilford Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A. McBride ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Wm. H. McBride
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1860

8. AGE: Years	Months	Days	If less than one day
88	9	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER FATHER
12. Name ? Keyhan
13. Birthplace ?
14. Maiden Name Ann Jones
15. Birthplace Maryland

16 (a) Informant Mrs. W. M. Wilhelm
(b) Address 3037 Guilford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John R. Moran
(b) Address 306 E. Balt. St

19 NOV 5 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3rd 1948 at 10 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to Nov 1948, and that I last saw her alive on Nov 3rd 1948

Immediate cause of death Bronchopneumonia — Duration 4 days.

Due to Contusions of face & nose; fracture of right femur

Due to

Other conditions Arteriosclerotic Cardio-Vascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

CERTIFICATION APPROVED BY
Wm. H. Kammer, M.D.
per Thomas T. Mellers M.D.
CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Oct 29, 1948 at 8 00 A M
(c) Where did injury occur? Balto Maryland - 18 (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell over a Chair

23. Signature William H Hefferd
Address 5006 Roland Ave Date signed 11/4/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G68305 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 36 N Lansley St
(c) Hospital or institution: L. 01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 36 N. Lansley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter S. Wisnowskey (Wisniewski)
3 (b) If veteran, name war —
3 (c) Social Security Account No. 217-01-3703

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Antonette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 26 1893

8. AGE: Years 55 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Simon Wisniewski
13. Birthplace Poland

MOTHER 14. Maiden Name Mary ?
15. Birthplace Poland

16 (a) Informant Antonette Wisnowskey
(b) Address 36 N Lansley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John E. Moran
(b) Address 3000 Baltimore St

19 (a) NOV 5 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1948 at 6 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from October 20 1948 to Nov. 3 1948 and that I last saw him alive on Oct 26 1948

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Coronary Artery Thrombosis	
Due to Arteriosclerosis Coronary Artery	
Other Conditions Arthritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. A. Flanigan M.D.
Address 3563 Fait Ave Date signed 11-3-48

Transcriber for Williams, Md. Registrar

VS 150

068306

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 92D

Register# [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5104 Whitford Ave
(c) Hospital or institution:
77-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5104 Whitford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phebe L. Moore

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widowed

6 (b) Name of husband or wife Gus Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1857 ?

8. AGE: Years	Months	Days	If less than one day
91 ?	2	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ? Maxwell
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. E. Kirby Lynch
(b) Address 5104 Whitford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave & Oliver St

18 (a) Funeral director John G. Moran
(b) Address 3009 E. Baltimore St

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3rd 1948, at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1948 to 11/3 1948, and that I last saw her alive on 11/3 1948.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	?
Due to Arteriosclerosis	?
Due to	
Other Conditions Cerebral Stem.	1 day

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lewis H. Carlson, M. D.
Address 2520 Talbot Rd. Date signed 11/5/48

VS 150

X

68307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G68307
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 E. Fort Ave
(c) Hospital or institution:
24-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa A. Kemp

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife Henry C. Kemp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 15-1877

8. AGE: Years	Months	Days	If less than one day
71	-	14.	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name James P. Carroll
13. Birthplace Ireland

MOTHER
14. Maiden Name ? Welsh
15. Birthplace Ireland

16 (a) Informant Mrs Anna T. Lewandowski
(b) Address 1408 E. Fort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St.

NOV 5 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1948, at 2.30a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947 to 1947, and that I last saw [illegible] alive on 19..

Immediate cause of death: Arteriosclerosis Cerebral Vascular Disease — Duration: 3 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Brenson M. D.
Address 107 S. West Date signed Nov 5, 1948

VS 152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68308

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days (23 hrs)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1277 East North Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARGARET CATALANO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife: Salvatore Catalano
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4, 1920

8. AGE: Years	Months	Days	If less than one day
28	3	29	hr. min.

9. Birthplace Braddock, Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Zeck
13. Birthplace Austria

MOTHER
14. Maiden Name Mary Suder
15. Birthplace Austria

16 (a) Informant Salvatore Catalano (husband)
(b) Address 1277 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore

18 (a) Funeral director Frank Della Noce
(b) Address 322 S. High St.

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1948, at 2.00PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Embolism, Left
Due to Bronchopneumonia

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed November 4, 1948

VS 151

68309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. G68309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 853 W Lexington
(c) Hospital or institution: 1601

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 853 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Chester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 5 [illegible]

8. AGE: Years 63 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation [illegible]

11. Industry or business

FATHER
12. Name John Chester
13. Birthplace Balto Md

MOTHER
14. Maiden Name Annie Jones
15. Birthplace Balto Md

16 (a) Informant Wife Baltimore
(b) Address 853 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof [illegible] (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Isaac H Brown Son
(b) Address 104 W Montgomery St

19 NOV 5 1948 (Date rec'd by Registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1948 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1948 to Nov 1 1948 and that I last saw h alive on Nov 1 1948

Immediate cause of death: Hypertensive Cardio Vascular Disease — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 5-5½ Dolphin St Date signed 11-3-48

VS 150

68310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 68310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 Edgewood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Edgewood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LULA MAE HANSROTE

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Lawrence

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 22, 1885

8. AGE: Years 63 | Months 5 | Days 11 | If less than one day: hr. min.

9. Birthplace: Pea Hill, Va. (Town, county, and state)

10. Usual Occupation: Saleslady

11. Industry or business: Hub Depa rtment Store

FATHER
12. Name: (Unknown) Guthridge
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Sarah (Unknown)
15. Birthplace: Unknown

16 (a) Informant: Adam Ha nsrote
(b) Address: 2426 14th ST. NW, Washnington, D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month) (day) (year)
(c) Cemetery or crematory: Fort Lincoln
Location: Washington D.C.

18 (a) Funeral director: William Cook, Inc
(b) Address: 1217 St. Paul St.

19 NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 3 1948, at 12 ~~00~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1947 to 11/3 1948 and that I last saw her alive on 11/1 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: 11/3/48

Due to: Hypertensive Cardio-vascular Disease — 1 yr +

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury:

23. Signature: T. B. Cook M.D.
Address 3629 Edmondson Date signed 11/4/48

VS 150

8311 BC-HP-22678 ✓ G68311

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 68311

CERTIFICATE OF DEATH 182a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 7-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROLAND YOUNG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1948

8. AGE: Years	Months	Days	If less than one day
		21	24 hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Ernest Young
13. Birthplace Approx. N.

MOTHER 14. Maiden Name Doris E. Young
15. Birthplace Balto. M.

16 (a) Informant John Ernest Young
(b) Address 1017 N. Gay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County

18 (a) Funeral director Mrs. Robert A. Elliott Dght.
(b) Address 1129 N. Caroline st.

19 NOV 5 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1948 at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Laceration of Jugular Vein

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 3/48 approx. 3:55 A.M. 7/4
(b) Where did injury occur? 1017 N Gay St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Razor

23. Signature Medical Examiner. M.D.

Date signed

X

68312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

Registered No. G68312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME OPLIN McINTOSH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 3, 1917

8. AGE: Years	Months	Days	If less than one day
31	1	10	hr. min.

9. Birthplace Saluda Co., South Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thadius McIntosh
13. Birthplace South Carolina

MOTHER
14. Maiden Name Es. Brooks
15. Birthplace South Carolina

16 (a) Informant Holland Funeral Home
(b) Address Lancaster, South Carolina

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 11-5-48 (month, day, year)
(c) Cemetery or crematory Lancaster
Location Lancaster, South Carolina

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1948 at 5 P.M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 3/48 at approx. 4 P.M.
(b) Where did injury occur? 1017 N. Calvert St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury burners on stove unlit

23. Signature [signature] M.D. Medical Examiner.
Date signed 11/4/48

VS 151

68313

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 121a

Registered No. 68313

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2734 Guilford Ave.
(c) Hospital or institution: 12-02
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2734 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAGGIE MAY QUARNGESER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife: Henry Quarngeser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Aug. 8, 1872

8. AGE: Years	Months	Days	If less than one day
76	2	27	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Andrew Stewart
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Ellingsworth
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. E. S. Quarngeser
(b) Address: Bush & Hamburg Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1948 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1948 to Nov 5 1948 and that I last saw her alive on Nov 4 1948

Immediate cause of death: Cerebral Hemmorhage — Duration:
Due to: arterio Sclerosis
Due to: Chronic Glomerulonephritis
Other Conditions: Senility-Anemia

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Manner of injury

23. Signature: Walter A Anderson M. D.
Address 3001 Hamonblie Date signed 11/6/48

VS 189

68314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. 68314

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 11-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 E Read St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME NELLIE, GERTRUDE KIEHNE

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 216-03-4928

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Div.

6 (b) Name of husband or wife: Charles W. Kiehne, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-1900

8. AGE: Years	Months	Days	If less than one day
48	0	23	hr. min.

9. Birthplace: Balto Md. (Town, county, and state)
10. Usual Occupation: Receptionist
11. Industry or business: State Employment Office

FATHER
12. Name: Harry H. MacLellan
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Nellie M. Jones
15. Birthplace: Rochester N. Y.

16 (a) Informant: Mr. Charles W. Kiehne, Jr. son
(b) Address: 1220 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Balto., Md.

18 (a) Funeral director: WILLIAM J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3- 1948 at 11-55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7- 1948 to 11-3-1948 and that I last saw her alive on 11-3- 1948.

Immediate cause of death
Cardiac failure
Due to Anemia
Due to Hypertension Arteriosclerosis

Duration
3 mos.

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Nephrosclerosis, Neoplasm of pancreas

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Rome, M.D.
Address Mercy Hospital Date signed 11-7-48

921

VS 180

G68315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. G68315

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 12-06
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 42 E. 26th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CATHERINE E. REYNOLDS

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Collin H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 28, 1888

8. AGE: Years 60 | Months 0 | Days 7 | If less than one day hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John M. Kaufman
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Mary C. Minnick
15. Birthplace: Balto., Md.

16 (a) Informant: Collin H. Reynolds
(b) Address 42 E. 26th St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11-8-48 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Baltimore, Md.

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul St.

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Huntington Mills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1948, at 12:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull c
intra-cranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 12/6
(a) Date of injury Nov. 5, 48 at 12:30 A. M.
(b) Where did injury occur? Charles & 24th St.
(c) Did injury occur at home, on farm, in industrial place, in public place? Public While at work? No
(d) Means of injury Ped. & Auto (Struck by)

23. Signature [illegible] M.D. Medical Examiner
Date signed 11/5/48

VS 151

68316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

Registered No. 68316

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3616 Wilkens ave.
(c) Hospital or institution: 75-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3616 Wilkens
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Elizabeth Leaf

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife: John H. Leaf deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/67

8. AGE: Years	Months	Days	If less than one day
81	4	19	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Frederick Abel
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Heidler
15. Birthplace Germany

16 (a) Informant Mrs. Walter Berryman
(b) Address Pikesville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Randallstown, Md

18 (a) Funeral director Frank H. Newell
(b) Address Pikesville, Md

NOV 5 1948 (Date rec'd by registrar) Washington Millhouse, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1948 at 9:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1948 to Nov 4, 1948, and that I last saw her alive on Nov. 4, 1948

Immediate cause of death	Duration
Acute coronary failure	
Due to Hypertension Cardio-vascular disease	
Due to	
Other Conditions Senile aphasia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis R. Mercer
Address 4335 Park Heights Ave Date signed 11/5/48

VS 180

X

68317

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 68317

Registered No. 68317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4207 Underwood Rd.
(c) Hospital or institution: (at home)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford.
(c) City or town Bel-Air (If outside city or town limits, write RURAL and give town)
(d) Street No. P.O. Box - 205 (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Canada.

3 (a) FULL NAME Ernest Lawrence Dinning

3 (b) If veteran, name war none

3 (c) Social Security Account No. 217-18-1583

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Norah L. Dinning (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Jan-4-1874

8. AGE: Years	Months	Days	If less than one day
74	10	0	hr. min.

9. Birthplace Quebec - Canada (Town, county, and state)
10. Usual Occupation Manfr.
11. Industry or business (Diversified)

PATHER
12. Name Henry Dinning
13. Birthplace Ireland

MOTHER
14. Maiden Name Etta Carpenter
15. Birthplace Canada.

16 (a) Informant E. L. Dinning - Jr. (Son)
(b) Address Hollins Rd - Lutherville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stewart Mortuary
(b) Address 108 W. Saratoga St.

19 (a) Nov 5 1948 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 4 - 1948, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to Nov 4 1948 and that I last saw him alive on May 1 1948

Immediate cause of death Cerebral Thrombosis — Duration 3 hrs.
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry F. Weinfeldt Jr. M.D.
Address 1101 St. Paul St. Date signed Nov. 5, 48

VS 150

G68318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

Registered No. G68318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) (3 months)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County Lake
(c) City or town Mount Dora (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 93 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frederic Burston (Frederic Jewell Burston)

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth W. Burston
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr) Aug 19 71

8. AGE: Years	Months	Days	If less than one day
77	2	17	hr. min.

9. Birthplace Va. Falls Church (Town, county, and state)
10. Usual Occupation Insurance Agent
11. Industry or business

FATHER
12. Name Charles Hall Burston
13. Birthplace N.Y.

MOTHER
14. Maiden Name Sarah Jewell
15. Birthplace Vermont

16 (a) Informant Mr. F. Dawson Burston (son)
(b) Address JOHNS HOPKINS HOSPITAL 103-20-39th St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Nov 8 48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Avenue

19 (a) NOV 5 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 NOV. 1948 at 9:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Oct 1948 to 4 NOV. 1948, and that I last saw him alive on 4 NOV. 1948.

Immediate cause of death	Duration
(a) Pulm. embolism	5 min
Due to (b) anemia + TVR	7 days
Due to (c) lower respiratory infection	
Other Conditions ASCVD	

(Include pregnancy within 3 months of death)
Date of operation Oct 28 48
Major findings of operation: OSPH
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilfred E. Burston
Address 4 NW Date signed 4 NOV. 48 (M. D.)

VS 150

668319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

118

Registered No. 668319

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 N Holly St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philippine Weber

3 (b) If veteran, name war: W
3 (c) Social Security Account No. NONE

4. Sex: F | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Hugo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12. 1871

8. AGE: Years 76 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Christian Lang
13. Birthplace Germany

MOTHER 14. Maiden Name Philippine Weber
15. Birthplace Germany

16 (a) Informant Mrs L. Le Barry
(b) Address 213 N Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Nelson Todd Inc
(b) Address 1217 E Fort Ave

19 (a) NOV 6 - 1948 (Date received by registrar) (b) Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4, 1948 19 . at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1948 to 11/4 1948. and that I last saw h alive on 11/4 1948.

Immediate cause of death: Gastric Hemorrhage — Duration
Due to: Hypertrophic Gastritis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Nov 2 1948
Major findings of operation: Bleeding from Hypertrophic Gastritis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen I. Moore M.D.
Address Sinai Hosp Dr Date signed 11-6-48

VS 150

668320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

668320 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 1907
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JACOB R. SATCHELL

3 (b) If veteran, name war: War II

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Delina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 18, 1914

8. AGE: Years (smt) 34 | Months 1 2 | Days 16 | If less than one day hr. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual Occupation: G.I. School

11. Industry or business: Tailor

FATHER
12. Name: Cabel J. Satchell
13. Birthplace: N. C.

MOTHER
14. Maiden Name: Rachel Bryant
15. Birthplace: N. C.

16 (a) Informant: Harry Frink
(b) Address: 7 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8-48 (month) (day) (year)
(c) Cemetery or crematory Richmond. Va
Location

18 (a) Funeral director: James A. Sayers
(b) Address: 142 W. Hico St.

19 NOV 6 - 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1948, at 4:05 AM

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral edema
d/t acute alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury
(e) Signature George C. Merrill M.D. Medical Examiner.
Date signed 11/4/48

VS 151

68321

Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

Registered No. 68321

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4212 Parkmont Ave.

(c) Hospital or institution: Parkmont Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) ?

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)

(d) Street No. R.F.D.No 5 Bx 159 Dogwood Road (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME AMOS E, TRIPLETT

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Annie M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec.4,1854

8. AGE: Years	Months	Days	If less than one day
93	11	1	hr. min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Ebinezer Triplett

13. Birthplace Baltimore Co., Md.

MOTHER

14. Maiden Name (Unknown) Lowe

15 Birthplace England

16 (a) Informant Mrs Michal Sullivan

(b) Address RFD 5 Box 159 Dogwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill

Location Towson, Md.

18 (a) Funeral director William Cook, Inc.

(b) Address 1217 St. Paul St.

19 (a) NOV 6 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948, at M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1947 to 1948, and that I last saw him alive on Nov. 4 1948.

Immediate cause of death	Duration
Bronchio Pneumonia	
Following	
Burn of face	
Due to weak on Nov. 1, 1948	
Due to Senility & Coronary Sclerosis	
Other Conditions Arteriosclerotic Gangrene of face	

(Include pregnancy within three months of death)

Date of operation CERTIFICATION APPROVED BY

Major findings of operation:

Homer J. Mascio M.D.

of autopsy: CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 36/1

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence November 1, 1948 at ? M

(c) Where did injury occur? 4212 Parkmont Avenue (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Nursing Home (Specify) While at work? No

(e) Means of injury While smoking pipe -- bandages on face caught fire

23. Signature T B Stevens M.D.

Address 3400 Edmondson Date signed 11/5/48

VS 150

G683222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

Registered No. G683222

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Beaumont Ave. #28 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: MILTON HENRY WALLACE

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-10-5150

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married

6 (b) Name of husband or wife: Gertrude E. Wallace
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) December 27, 1900

8. AGE: Years	Months	Days	If less than one day
47	10	7	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Freight Agent
11. Industry or business Western Md. R. R.

FATHER
12. Name Joseph Wallace
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Shaffer
15. Birthplace Germany

16 (a) Informant Gertrude E. Wallace
(b) Address 107 Beaumont Ave. #28

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 6 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1948, at 8 37 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1948, to 11/4 1948, and that I last saw h[illegible] alive on 11/4 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Uremia	5 days
Due to Chronic Glomerulonephritis	8
Other Conditions Hypertension (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Md. Gen. Hosp. Date signed 11/5/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

668323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

668323 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Springdale Ave. Balt. 7
(c) Hospital or institution: Virginia Lewis Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Braddish Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY PRIESTERJAHN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 25, 1878

8. AGE: Years	Months	Days	If less than one day
69	11	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation Retired Silversmith
11. Industry or business S. Kirk & Son

FATHER
12. Name Charles A. Priesterjahn
13. Birthplace Germany

MOTHER
14. Maiden Name Mary A. Wolff
15. Birthplace Germany

16 (a) Informant Miss Bertha Priesterjahn, sister
(b) Address 1507 Braddish Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 6 - 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1948, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 21 1948 to November 5 1948, and that I last saw him alive on Nov 3 1948.

Immediate cause of death	Duration
Arteriosclerotic cardiovascular disease	10 years
Due to	
Due to	
Other Conditions Hypertensive cardiovascular disease (Include pregnancy within 3 months of death)	5 years

Date of operation Sept 1948
Major findings of operation: Benign prostatic hypertrophy. Bilateral Ingvinal hernea
Autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Millard T. Traband M.D.
Address 3400 Woodbine Ave, Balt. 7 Date signed 11/5/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

Registered No. G68324

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reisden Ave. & Wolfe St
(c) Hospital or institution: Maryland Genl Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 15 6
(e) Length of stay in Baltimore (yrs., mos., or days) 72 years 15 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3026 Walbrook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie May Dale

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Fe | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5, 1876

8. AGE: Years 72 | Months 3 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business —

FATHER 12. Name Robert Dale
13. Birthplace Baltimore

MOTHER 14. Maiden Name Margret Miller
15. Birthplace Baltimore

16 (a) Informant Rev. Hoake E. Cusick
(b) Address Westminster, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 6 1948 (Date rec'd by registrar) (b) Huntington Millican M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5 1948, at 5:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4 1948 to 11-5 1948 and that I last saw her alive on 11-5 1948.

Immediate cause of death: Acute Hemorrhagic Gangrenous Cystitis — Duration: Week

Due to: Papilloma of Bladder — Duration: Months

Due to:

Other Conditions: Anemia

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: 11-5-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. Friedel M. D.
Address Md. Genl Hosp. Date signed 11-5-48

VS 180

68525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

XJ 68525 Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Belcamp (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LEPOT MULLER (LEO MILLER)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary Muller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1912

8. AGE: Years 36 | Months 5 | Days 28 | If less than one day: hr. min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation Storekeeper

11. Industry or business

FATHER 12. Name Lajos Muller
13. Birthplace Hungary

MOTHER 14. Maiden Name Illona Vorst
15. Birthplace Hungary

16 (a) Informant Mary Muller
(b) Address Belcamp, Maryland

17 (a) Interment (b) Date thereof Nov. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Charles P. Nagel
Location 352 E. 67 St New York City

18 (a) Funeral director Howard K. McCubbin & Son
(b) Address Abingdon Maryland

19 (Date rec'd by Registrar) NOV 6 1948 Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 19 48, at 3:35 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-4-48 at 3:15 P M?
(b) Where did injury occur? 500' E. of Chesapeake Ave. nr. Phila. Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury auto into culvert

23. Signature Earle Rogers M.D. Medical Examiner.
Date signed November 5, 1948

X

668326

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

668326 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1535 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1535 N. Fulton Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Rev.) John Hendrick Johnson

MEDICAL CERTIFICATION

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Sarah F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1861

8. AGE: Years	Months	Days	If less than one day: hr.	min.
67	2	7		

9. Birthplace Jackson, Miss. (Town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business

FATHER
12. Name John Hendrick Johnson
13. Birthplace Jackson, Miss.

MOTHER
14. Maiden Name Hattie ? ?
15. Birthplace Jackson, Miss.

16 (a) Informant Mrs. Sarah F. Johnson
(b) Address 1535 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Cem.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Clarke
(b) Address 1691 Druid Hill Ave.

19 NOV 6 1945 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

20. DATE OF DEATH Nov 4 1945 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1945 to Nov 4 1945, and that I last saw h[illegible] alive on Nov 2 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Arteriosclerosis	17 yrs
Due to Hypertension	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3426 Elm [illegible] Date signed 11/6/45

VS 150

668327

48-12327

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 19

668327 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 E. Chase St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Hite

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: fe | 5. Color or race: n | 6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 9 hr. 30 min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John R. Hite
FATHER 13. Birthplace ~~Balto~~. Victoria Va

MOTHER 14. Maiden Name Louie Gentry
MOTHER 15. Birthplace Roxboro N.C.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director Returned by hospital
(b) Address Atlanta, Ga.

19 NOV 6 - 1948 (Date rec'd by registrar) (b) Thurlington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7-48 19 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death: Congenital atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 102 Druid Hill Ave Date signed 6-7-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

668328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 668328

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 802 N Hilton ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 802 N Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LURA E. HOLBROOK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~of wife~~ William B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1877

8. AGE: Years	Months	Days	If less than one day
71	3	22	min.

9. Birthplace Baltimore (Town, county, state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name George T. Sheale?
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Wm. B. Holbrook
(b) Address 802 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) NOV 6 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 19 48 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 1920 to Nov 3 1948
and that I last saw h alive on Nov 3 1948

immediate cause of death

	Duration
Cerebral Hemorrhage	2 hrs.
Due to Hypertension (Arteri)	20 yrs
Due to Chronic Nephritis	20 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature L. A. Tally
Address 351 Edmondson Ave. Date signed Nov 5 1948 (M.D.)

VS 150

68329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 83a

Registered No. 68329

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calow & Wilkins
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 Arbutus Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Lang -

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	widowed

6 (b) Name of husband or wife Nicholas T. Lang
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3-7-65

8. AGE: Years	Months	Days	If less than one day
83	7	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation President
11. Industry or business Aseptinol Mfg. Co.

FATHER
12. Name James Welslager
13. Birthplace Md.

MOTHER
14. Maiden Name Henrietta Harken
15. Birthplace Md.

16 (a) Informant William C. Rogers
(b) Address 1525 Munsey Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ New Cathedral
Location Baltimore, Md.

18 (a) Funeral director John B. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place

19 (a) NOV 6 1948 (Date rec'd by registrar) (b) Huntington Northallerton, M... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5/ 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-2 1948 to Nov 5 1948, and that I last saw h alive on 19

Immediate cause of death CARDIO-RESPIRATORY FAILURE — Duration

Due to CEREBRAL VASCULAR ACCIDENT

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B. Shaw M. D.
Address St. Agnes Hosp. Date signed 11/6/48

VS 150

X

68330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. 68330

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2419 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2419 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS PAUL MEYER, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ida Brodt Meyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1873

8. AGE: Years	Months	Days	If less than one day
75	4	19	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant: Mrs. Ida Brodt Meyer
(b) Address 2419 E. Madison St.

17 (a) Burial (b) Date thereof 11/6/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & [illegible]ay St.

18 (a) Funeral director Schimmel[illegible]uneral Home, Inc.
(b) Address 2601-3-5 E. Madison St.

19 NOV 6 - 1948 (b) [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1948, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to inhalation of illuminating gas.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 4/48, approx. 9 A.M.
(b) Where did injury occur? 2419 E. Madison St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury 3 burners on but unlit

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 11/4/48

VS 151

668331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

✓ 668331 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4000 Ridgecroft Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4000 Ridgecroft Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edward I. Radecke

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Bertha (nee Gosper)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 2, 1902

8. AGE: Years	Months	Days	If less than one day
46	-	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Boston Metal Company

FATHER
12. Name Jacob Radecke
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Hyjak
15 Birthplace Germany

16 (a) Informant Mrs. Bertha Radecke
(b) Address 4000 Ridgecroft Road

17 (a) Burial (b) Date thereof 11/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem.
Location

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 NOV 6 - 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/48 19 1215 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 1948 to 11/4 1948 and that I last saw h— alive on 11/3 1948.

Immediate cause of death Carcinoma of the Colon — Duration 7

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel L. Gross M. D.
Address 1769 E. Monument Street Date signed 11/5/48

VS 150

668332 Picozzi

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 668332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 N. Castle St (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country Italy

3 (a) FULL NAME Mrs. Mary D.C. Picozzi

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-7116

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Carlo Picozzi

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-22-92

8. AGE: Years	Months	Days	If less than one day
56	10	4	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name —
13. Birthplace Italy

MOTHER
14. Maiden Name —
15. Birthplace Italy

16 (a) Informant Carlo Picozzi
(b) Address 608 N. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Rose St.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 NOV 6 - 1948 Huntington Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4-48 19 . at 1.07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1948. to 11-4 1948.
and that I last saw h.r. alive on 11-4 19 48

Immediate cause of death	Duration
Cardiac Arrest	
Due to Cerebrovascular Accident	Instant
Due to Arteriosclerosis, Gen'd.	
Other Conditions Diabetes mellitus	3 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard Covert, Jr. M. D.
Address Henry Hosp Date signed 11-7-48

VS 150

668333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 668333

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 842 Mangold St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Preuhe (Preubis)

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-2465

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Lith, (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Semas Preubis
13. Birthplace Lith

MOTHER
14. Maiden Name
15. Birthplace Lith

16 (a) Informant Bertha Preubis
(b) Address 842 Mangold St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Joseph Kaminkow Sr.
(b) Address 69 Washington Blvd

19 (d) NOV 6 - 1948 (Date rec'd by registrar) Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4 1948, at 8:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 1948 to 11-4 1948, and that I last saw h alive on 11-4 1948.

Immediate cause of death Intracerebral hemorrhage — Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Evans M.D.
M. D.

Address University Hosp. Date signed 11-5-48

68334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. 68334

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1341 Mosher St.
(c) Hospital or institution:
flor

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1341 Mosher St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence D. Caldwell.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Separated

6 (b) Name of husband or wife Mamie Caldwell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 10, 1897

8. AGE: Years	Months	Days	If less than one day
51	10	~ 24	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Robert Caldwell
13. Birthplace Md.

MOTHER
14. Maiden Name Carrie Waters
15. Birthplace Toronto, Canada.

16 (a) Informant Ethel Morrison.
(b) Address 1341 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date received by reg.) NOV 6 1948 (b) Huntington Hilleary, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1948, at 2:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Nov 3 1948 and that I last saw him alive on Oct 26 1948

Immediate cause of death: Coronary occlusion — Duration: Unkn

Due to

Due to

Other Conditions Aortic Insufficiency Unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Garland Shreeve Jr. M.D.
Address 902 W. Franklin Date signed 11-5-48

X

G68335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No. G68335

CM. 124275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1538 Holland Ave. (If rural give location)
(e) Citizen of foreign country? Harlem (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Arthur Washington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) January 1, 1892

8. AGE: Years	Months	Days	If less than one day
56	10	3	hr. min.

9. Birthplace ? Newport News, Va.,
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Henry Coy
13. Birthplace Newport News, Va.

MOTHER
14. Maiden Name ? Mary
15. Birthplace Newport News, Va.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Interred (Burial, cremation, or removal) (b) Date thereof Nov 6, 1948 (month) (day) (year)
(c) Cemetery or crematory Framingdale
Location National Cemetery N. Y.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) NOV 6 - 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11- 4 - 19 48 at 2.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11- 3- 19 48 to 11- 4- 19 48 and that I last saw her alive on 11- 4 - 19 48.

Immediate cause of death Sub-arachnoid hemorrhage-ruptured into ventricles — Duration Hrs

Due to aneurysm ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. T. Nelson M. D.
Address BCH Date signed 11-4

VS 150

G68336
B-124281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 82a

Registered No. G68336

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)

(d) Street No. 19 Midway zone 22
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Beatrice Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Vernon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 15-1899

8. AGE: Years	Months	Days	If less than one day
48	11	20	hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER

12. Name Harry J ?Tully

13. Birthplace Pennsylvania

MOTHER

14. Maiden Name Mrs. Gracey

15. Birthplace Pennsylvania

16 (a) Informant Records -Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) ~~Cremation~~ Burial (b) Date thereof Nov 9-48
(Burial, ~~cremation~~, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Avenue

18 (a) Funeral director Chas. F. Evans & Son

(b) Address 1[illegible] Mt Royal Ave

19 (a) NOV 6 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5- 1948, at 5.15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-3- 1948, to 11-5- 1948, and that I last saw h[illegible] er alive on 11-5- 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	48 hrs
Due to Essential hypertension	12 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature John E. Buchtold M. D.

Address Balto City Hosp. Date signed 11-6-48

VS 150

X

668337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 668337

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 19-04
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 321 S. Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SAMUEL FRANK HARMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-12-2334

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Elsie H. Harman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep. 2, 1900

8. AGE: Years	Months	Days	If less than one day
48	9 2	26 3	hr. min.

9. Birthplace Carroll Co., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Railroader

FATHER
12. Name Chas. H. Harman
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Carrie Wilhide
15. Birthplace Carroll Co., Md.

16 (a) Informant F. A. Sharrer
(b) Address Westminister, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem.
Location Westiminister, Md.

18 (a) Funeral director F. A. Sharrer
(b) Address Westminister, Md.

19 (a) NOV 6 - 19[illegible] (Date rec'd by registrar) (b) Huntington Nelligan, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1948 at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl K. Rogers, M.D. (Medical Examiner)
Date signed 11/5/48

VS 151

668338

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 128

668338 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1946 Sponson Street
(c) Hospital or institution: ~~Union Memorial~~ (Died en route)
(d) Length of stay in hospital or inst. (yrs., mos., or days) *****
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1946 Sponson Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN NORATEL

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-07-3165

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife EVA B. NORATEL
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr) Sept- 28 -1885

8. AGE: Years	Months	Days	If less than one day
63	1	5	***** hr. ***** min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name John Noratel
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Unknown
15. Birthplace Czechoslavakia

16 (a) Informant (Wife) Mrs. Eva B. Noratel
(b) Address 1946 Sponson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Maryland

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE...17

19 (a) Date received NOV 6 [illegible] (b) Registrar [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1948, at 4:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 8 1948, to 19 48, and that I last saw him alive on Nov 1 19 48

Immediate cause of death Tuberculosis of Lungs & Kidneys.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Arthur Rosenberg M.D.
Address 2411 WASHINGTON BLVD. Date signed 11/ /48 M, D

VS 150

Dr. C. Arthur Rosenberg

6839 # 7 # 36

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 737

Registered No. 66839

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs 4
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3721 ½ Hanover St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Nick~~ Pappas - Nicholas Christ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-10-38

8. AGE: Years 10 | Months 5 | Days 25 | If less than one day: hr. min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Christophe - Pappas
13. Birthplace Greece
14. Maiden Name Kitty Laccas
15. Birthplace Greece

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6-48 (month) (day) (year)
(c) Cemetery or crematory Greek - [illegible]
Location Woodmere Md.

18 (a) Funeral director Symbras - Funeral Home Inc
(b) Address 440 East North Ave. Baltimore, Md

19 (a) NOV 6 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4-1948 at 1:43 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15-1948 to 11-4-1948 and that I last saw him alive on 11-4-1948

Immediate cause of death	Duration
Anaemia	
Due to Erythroblastic anaemia (Cooley's)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Fang M. D.
Address John's Hopkins Hosp Date signed 11-4-48

VS 15)

68340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 68340

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3133 Virginia Ave.,
(c) Hospital or institution:
17-16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3133 Virginia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John George Ochs.

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elizabeth C. Ochs

6 (c) If alive, give age yedrs

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1872

8. AGE: Years	Months	Days	If less than one day
76	1	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation retired Interior Decorator,
11. Industry or business

FATHER
12. Name Adam Ochs.
13. Birthplace Germany,

MOTHER
14. Maiden Name unknown
15. Birthplace Germany,

16 (a) Informant Mrs. Elizabeth C. Ochs.
(b) Address 3133 Virginia Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Le Vernon Lemmon
(b) Address 4611 Park Heights Ave.,

NOV 6 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1948 at 8.40 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1948 to 11/4 1948.
and that I last saw him alive on 11/4 1948.

Immediate cause of death Coronary Thrombosis

Duration 10/20/48

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Buckel M. D.
Address 4803 Park Heights Date signed

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

68341 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County York
(c) City or town Delta (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Graton Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 7 1891

8. AGE: Years	Months	Days	If less than one day
56	10	30	hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Delmar Thompson
13. Birthplace Penna

MOTHER 14. Maiden Name Elizabeth Ramsey
15. Birthplace Penna

16 (a) Informant Edwin Thompson
(b) Address Delta, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Slate Ridge
Location York Co. Pa.

18 (a) Funeral director Hubert P. Jenkins
(b) Address Delta, Pa.

19 (a) Date received by Registrar Nov 9 1948 (b) Registrar Washington Hollinsworth M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1948, at 12:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1948, to Nov 6 1948, and that I last saw him alive on Nov. 6 1948.

Immediate cause of death Pulmonary embolism

Due to Pneumonia

Due to Rheumatic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A Smith Jr M. D.

Address Date signed

VS 150

G68342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G68342
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Years
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 N. Smallwood St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Wiedmaier, Bernhard. (Bernhard Wiedmaier)

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rosa L. Wiedmaier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 24, 1884

8. AGE: Years 64 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Tavern keeper

11. Industry or business Self

FATHER
12. Name Christian Wiedmaier
13. Birthplace Germany

MOTHER
14. Maiden Name Magdelina Egner
15. Birthplace Germany

16 (a) Informant Rosa Louisa Wiedmaier
(b) Address 11 S. Smallwood Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director George J. Schwab
(b) Address 2101 Frederick Ave.

19 (a) NOV 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5 1948, at 8 10 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-5 1948 to 11-5 1948, and that I last saw him alive on Nov 5 1948.

Immediate cause of death: Pulmonary edema + congestive Ht. failure
Due to arteriosclerosis, diabetes, cirrhosis
Due to
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. L. J. Finkell M. D.
Address Franklin Sq. Hosp. Date signed 11-5-48

X

G68343 ✓ X G68343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 461

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md (b) County a e
(c) City or town Brest Gate
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) **FULL NAME** Benjamin C Britton (Brittain) Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Rose Eva Brittain
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26 1893

8. AGE: Years	Months	Days	If less than one day
55	7	11	hr. min.

9. Birthplace Coalport Maryland
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name George H Brittain
13. Birthplace Coalport Md

MOTHER
14. Maiden Name Elizabeth Colburn
15. Birthplace Annapolis Md

16 (a) Informant Rose Eva Britton
(b) Address Annapolis Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9 48 (month) (day) (year)
(c) Cemetery or crematory Locust Knoll
Location Annapolis Md

18 (a) Funeral director C H Hopkins & Son
(b) Address Annapolis Md

19 NOV 7 1948 Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 6 1948 at 4.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 28 48 19 to 11 6 19 48.
and that I last saw h 11 6 alive on 11 6 19 48

Immediate cause of death	Duration
Cardiac Arrest	
Due to Coronary Thrombosis	
Due to Carcinoma of Rectum Postoperative	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10 28 48
Major findings of operation: Carcinoma Rectum
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R C Longwell M. D.
Address University Hospital Date signed 11/6/48

Baltimore 2, MD X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. G68344

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3040 Hudson st.
(c) Hospital or institution: 1-01
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3040 Hudson st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Ekielski

3 (b) If veteran, name war

3 (c) Social Security Account No 216-03-2346

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Bertha Ekielski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 5/1877

8. AGE: Years 71 | Months 8 | Days — | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Steinmowicz Bro

FATHER
12. Name unknown
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs Bertha Ekielski
(b) Address 3040 Hudson st

17 (a) Burial (b) Date thereof Nov 8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill road

18 (a) Funeral director Stephen J. Fialkowski
(b) Address 1000 S. Kenwood ave

19 (a) NOV 7 1948 Ruth [illegible]
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948 at 2:55 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1948, to Nov 5 1948, and that I last saw h alive on Nov 5 1948.

Immediate cause of death
Chr. Myocarditis
Duration 11-2-48
Due to Senile Coronary Sclerosis
Duration 11-2-48
Due to
Duration 11-5-48
Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eli Schimunek M. D.
Address 84 S E Ave Date signed 11-5-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G68345

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 S. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Ford.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-21-86

8. AGE: Years	Months	Days	If less than one day
62	1	13	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jessie Ford
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Sterling
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov. 9-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem
Location Baltimore, Md

18 (a) Funeral director Chas O. Wilson
(b) Address 6000 Belmont ave

NOV 1 - 1948 (b) Williams, M... Registrar
(Date rec'd by ...)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1948, at 10 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3- 1948 to 11-4 1948, and that I last saw him alive on 11-4 1948.

Immediate cause of death: Acute pulmonary edema.
Due to: Coronary insufficiency
Due to: A.S. C.V.D.
Other Conditions: Multiple subcutaneous

Duration: 2 hours / many years / 6 mos

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: see above.
Was autopsy?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Hosp.
Address Date signed 11/5/48 M. D.

92a

G68346 ✓ G68346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 605
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Caroline Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM BISHOP HILL

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1929 or 23

8. AGE: Years	Months	Days	If less than one day
26	8	21	hr. min.

9. Birthplace Jayeso, Miss. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant Thomas Harding
(b) Address 1633 E. Fayette Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cemetery
Location Balto., Md.

18 (a) Funeral director Chas O. Wilson
(b) Address 1000 Edenton ave

19 NOV 7 - 1948 (Date rec'd by registrar) (b) Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1948 at 11:56 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab-wound of heart.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-29-48 at 11:30 P. M.
(b) Where did injury occur? Fayette & Dallas St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Sharp instrument

23. Signature George L. Merrill M.D. (Medical Examiner.)
Date signed 10-30-48

Huntington Williams, Registrar

X

G68347 Rugland ✓ G68347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-01
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Rugland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Helen Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2-2-70

8. AGE: Years	Months	Days	If less than one day
78	9	-	hr. min.

9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Perry Rugland
13. Birthplace Ala.

MOTHER
14. Maiden Name Frances Threet
15. Birthplace Ala.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Comm
Location Brooklyn Md
18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Baltimore ave

19 (a) NOV 10 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1948, at 8 25 P M

21. I certify that death occurred on the date above stated: that I attended deceased from 9-22 1948, to 11-2 1948, and that I last saw him alive on 11-2 1948.

Immediate cause of death	Duration
Cachexia	
Due to Carcinomatosis	
Due to Carcinoma of colon	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10/2/48
Major findings of operation: Carcinoma of colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard F. Ruffin, Jr. M.D.
Address Johns Hopkins Hosp. Date signed 11/2/48

G68348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68348 Registered No. 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 528 N. Caehorn St.
(c) Hospital or institution: 19-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 N. Caehorn St. (If rural give location)
(e) Citizen of foreign country? yes (Yes or No) If yes, name country British West Indies

3 (a) FULL NAME Henry John Landsdowne LANSDOWNE
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Roslyn Landsdowne LANSDOWNE
6 (c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr) Jan. 9 1884
8. AGE: Years 67 | Months 9 | Days 26 | If less than one day hr. min.
9. Birthplace British West Indies (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business B & O Shop

FATHER
12. Name David Landsdown LANSDOWNE
13. Birthplace B. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace B. Md.

16 (a) Informant Mrs Vera L. Gray
(b) Address 1816 N. Fulton Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 7-1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Parks
Location Arbutus Md
18 (a) Funeral director Elroy O. Wilson
(b) Address 1005 Blakelyard
19 (a) NOV 7 - 1948 (b) (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 4 - 1948 at 5:15 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 9-26-1948 to 11-4-1948, and that I last saw him alive on 11-3-1948

Immediate cause of death: Bronchopneumonia — Duration: 39 days
Due to
Due to
Other Conditions Cerebral hemorrhage — 1 year
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker Date signed 11-4-48

VS 158

107

G68349

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 181

G68349

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 St. Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miss Anna Farmer

3 (b) If veteran, name war . | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 19, 1890

8. AGE: Years 58 | Months 3 | Days 14 | 17 | Hours | Min. | If less than one day

9. Birthplace Baltimore City (Town, county, and state)

10. Usual Occupation school teacher

11. Industry or business

FATHER 12. Name Joseph L. Farmer

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary Adams

15. Birthplace Baltimore Md.

16 (a) Informant Mrs Charles L. Farmer

(b) Address 2905 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Rd

18 (a) Funeral director Moran, John A.

Address 4201 York Rd.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948, at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-14 1948 to 11-5 1948 and that I last saw h[illegible] alive on 11-5 1948.

	Duration
Immediate cause of death Cardiac Resp. failure	
Due to Hepato-Renal Insufficiency	
Due to Overwhelming Mania from 1st, 2nd & 3rd degree burns	
Other Conditions Hypertensive Cardiovascular Disease Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation CERTIFICATION APPROVED BY

Major findings of operation:

for C. J. Jirmski M.D.

of autopsy: CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 11-5-48 at 3:05 P M
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? No (Specify type of place)
(e) Means of injury Fell in tub of boiling water

23. Signature Charles E. Carter M. D.

Address St Agnes Hosp. Date signed 11-5-48

for Approved Medical Examiner

VS 150

G68350 ✓ G68350

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 N. Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 N. Wolfe St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Lindsay Mosby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widow

6 (b) Name of husband or wife Jessie Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17, 1888

8. AGE: Years	Months	Days	If less than one day
59 160	10	17	hr. min.

9. Birthplace York County S. C. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Sam Meeks
13. Birthplace S. C.

MOTHER
14. Maiden Name Jane Thompson
15. Birthplace S. C.

16 (a) Informant Bessie Stewart
(b) Address 814 N. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8/48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A. A. County

18 (a) Funeral director Mrs. Pitt. Allen & Son
(b) Address 1129 N. Carolina St.

19 (a) [illegible] (b) Date rec'd NOV 7 1948 Registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4-1948 at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29/48 to 11-4-1948. and that I last saw 24 alive on 11-4-1948.

Immediate cause of death (a) Hepatitis
Due to (b) Hypercalcitis
Due to (c) Cystic-renal.
Due to (d) Sclerosis

Duration
2 yrs
6 mos
12 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. W. Kuhl, M.D.
Address 1603 N. Caroline Date signed 11/9/48

G68351 ✓ G68351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 N. Eden St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miles Sherill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 15, 1878

8. AGE: Years	Months	Days	If less than one day
70	-	20	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER 12. Name Dan Sherill
13. Birthplace S. C.

MOTHER 14. Maiden Name Margaret?
15. Birthplace S. C.

16 (a) Informant Jennie Sherill
(b) Address 518 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 7/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County Md.

18 (a) Funeral director Mrs. M. E. Elbert & Son
(b) Address 1029 N. Carlin St.

19 (a) 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4 1948, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1- 1948, to 11-4- 1948, and that I last saw him alive on 11-4- 1948.

Immediate cause of death Myocarditis
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 6 mos 9 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)
(e) Means of injury

23. Signature H. W. Williams M.D.
Address 503 N. Carolina Date signed 11/4/48

668352

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47

668352 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or Institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3705 Melno Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maurice J. Goodman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	MARRIED

6 (b) Name of husband or wife Jean
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years (55) 54 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Liquor business

11. Industry or business

FATHER 12. Name Henry
13. Birthplace Russia

MOTHER 14. Maiden Name Anna
15. Birthplace Russia

16 (a) Informant Jean Goodman
(b) Address 3705 Melno Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 210 Eutaw Place

19 (a) Date received by registrar (b) Registrar

NOV 7 - 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6 1948 at 7:20 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 10-6 1948 to 11-6 1948, and that I last saw him alive on 11-6 1948.

Immediate cause of death: Ca of lung & metastases — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Ca of lung & metastases

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roger Strauss M. D.
Address Sinai Hosp. Balt Date signed 11-6-48

668353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

668353
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-1-01
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1140 Warner St (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Sandler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of husband or wife Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3-9-91

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business

FATHER
12. Name Manuel
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Lena Sandler
(b) Address 1140 Warner St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jacob Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) Filed (b) Registrar's signature Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1948 at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1948 to Nov. 6 1948.
and that I last saw him alive on Nov. 6 1948.

Immediate cause of death Complete coronary occlusion — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Kadin M. D.
Address 2306 Eutaw Pl Date signed 11-6-48

668354 668354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 Warwick Ave
(c) Hospital or institution: 15-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Warwick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Goldie Abramovitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 68 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name Solomon
13. Birthplace Russia

MOTHER
14. Maiden Name Molge
15. Birthplace Russia

16 (a) Informant Henry Abramovitz
(b) Address 1803 Warwick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eastern Place

19 (a) NOV 7 - 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 - 1948 at 1 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 6 1948 to 11/7 1948 and that I last saw h[illegible] alive on 11/6/1948

Immediate cause of death: Coronary Thrombosis — Duration: 15 min

Due to: Hypertensive Cardio-Vascular Disease — Duration: ?

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F. Lerner M. D.
Address 2401 N. North Ave Date signed 11/7/48

VS 150

G68355 ✓ G68355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Johnson
(c) Hospital or institution:
Hosp. Women Maryland 07
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Wks.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wyman Apts - 11
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle Ammidon (ESTELLE-JOSEPHINE-HOYT-AMMIDON)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widowed

6 (b) Name of husband or wife Daniel G Ammidon
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept - 23 - 1876

8. AGE: Years	Months	Days	If less than one day
72	1	14	hr. min.

9. Birthplace Stanford - Conn.
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name George Hoyt
13. Birthplace Stanford - Conn

MOTHER
14. Maiden Name Josephine Bailey
15. Birthplace ? - Conn.

16 (a) Informant Estelle Ammidon (Self)
(b) Address Wyman Apts - Balto - 11

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 - 9 - 48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Stamford Conn

18 (a) Funeral director Stewart Memorial
108 Mt Ave
(b) Address Baltimore

19 (a) [illegible] Washington Boulevard
(Date received by registrar) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 6 - 1948, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct - 16 1948 to Nov 6 - 1948, and that I last saw her alive on Nov - 6 - 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Intestinal obstruction	
Due to Carcinoma of Uterus	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Carcinoma of Uterus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George H. Goldsmith M. D.
Address Hosp. Women Md. Date signed 11 - 6 - 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

G68356

JL - 121502

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52B

G68356 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 13 08
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 W. 36th. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mandy Crawford

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Charles (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9 1865

8. AGE: Years	Months	Days	If less than one day
83 86 ?	7		hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Daniel Daffin
13. Birthplace Va.

MOTHER
14. Maiden Name Fannie Delaney
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8, 1948 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Hampden

18 (a) Funeral director Paul E. Shannon with Jr.
(b) Address 3615-12 Chestnut Ave

19 (a) NOV 7 - 1948 (b) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948, at 4.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1948 to Nov. 5 1948, and that I last saw her alive on Nov. 5 1948.

Immediate cause of death	Duration
Carcinometosis	
Due to Carcinoma of bladder	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7/27/48 (Cystoscopy)
Major findings of operation: Carcinoma of bladder
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. P. Novinsky
Address Balto City Hosp Date signed 11/6/48 M. D.

VS 150

G68357

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 937

G68357
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillian Lenhardt

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-7488

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25, 1889

8. AGE: Years	Months	Days	If less than one day: hr.	min.
59	9	10		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Sanitary Hotel

FATHER
12. Name Charles Long
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant John Long
(b) Address 117 N. Eldwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md

18 (a) Funeral director Uffelfinger Funeral Home
(b) Address 2008 Orleans St.

19 (a) 11/7/48 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5 1948 at 1 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26 1948 to 11-5 1948, and that I last saw her alive on 11-5 1948.

	Duration
Immediate cause of death Uremia	
Due to Hypertensive Cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jerome Gaber M. D.
Address Sinai Hosp Date signed 11-5-48

VS 190

G68358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G68358
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 847 Woodward St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 847 Woodward St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Albert Clayton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14, 1878

8. AGE: Years 70 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace York Md.
(Town, county, and state)

10. Usual Occupation Car repairman

11. Industry or business B & O R.R. Co

FATHER 12. Name Jesse Clayton
13. Birthplace York Md

MOTHER 14. Maiden Name Brands
15. Birthplace York Md

16 (a) Informant John F. Clayton
(b) Address 1705 Scott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory York M.E. Church
Location York Md

18 (a) Funeral director Ulmer Funeral Home
(b) Address 2008 Eutaw St Baltimore, Md

19 (a) Nov 9 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948, at 3P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7th 1946 to Nov 5 1948 and that I last saw h-- alive on Nov 5th 1948.

Immediate cause of death: Myocarditis — Duration: 7 years

Due to: Arteriosclerosis — Duration: 9 yrs

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Clayton
Address 517 Scott St. Date signed 11/6/48.

VS 150

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68359

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47

G68359
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 513 S. Fulton ave
(c) Hospital or institution: 1904

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 S. Fulton ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Nelson Hoffman Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Ella Young Hoffman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 12-1892

8. AGE: Years	Months	Days	If less than one day
56	1	22	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Home Maker
11. Industry or business Foundery

FATHER
12. Name Thomas B. Hoffman
13. Birthplace Md

MOTHER
14. Maiden Name Emma B. Harrison
15. Birthplace Md

16 (a) Informant Mrs. Ella Y. Hoffman
(b) Address 513 S. Fulton ave

17. (a) Burial (b) Date thereof 11-8-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md.

18 (a) Funeral director Geo. E. Bender Jr.
(b) Address 1512 Hollins St.

19 (a) Washington Undertaking Co.
(Date rec'd by Registrar) (Registrar)

NOV 1 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4- 1948, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21- 1946 to Nov 4 1948, and that I last saw him alive on Nov 4- 1948.

Immediate cause of death	Duration
Carcinomata of Lungs	
Due to Uncertain.	
Due to	
Other Conditions, Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Stetch M. D.
Address 217 Wilkins Date signed 11/1/48

38360

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

Registered No. 668360

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.
(c) Hospital or institution:
15-07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Denison Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Emma V. Micou

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1850

8. AGE: Years 97 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Micou
13. Birthplace Va.

MOTHER
14. Maiden Name Ann, Rawlings
15. Birthplace Md.

16 (a) Informant Mrs. Emma A. Campbell
(b) Address 4608 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves

19 (a) NOV 3 1948 (Registered by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6/ 19 48 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1948 to Nov. 6 1948, and that I last saw h[er] alive on Nov. 6 1948.

Immediate cause of death Cardio-Pasmular disease — Duration 3-4 yrs.

Due to General Arteriosclerosis Duration

Due to

Other Conditions Senile Edema of Lungs — Duration 8-10 hrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 2504 St Paul St. Date signed 11/7/48

VS 150

Cancer age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68361

61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County York
(c) City or town East Prospect (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harold Kline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	M

6 (b) Name of husband or wife Phylis

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr) 9-26-06

8. AGE Years	Months	Days	If less than one day
42	01	11	10 hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Stone Quarry

11. Industry or business

FATHER 12. Name	George Kline
13. Birthplace	Pa
MOTHER 14. Maiden Name	Ida Harris
15. Birthplace	Pa

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-7-48 (month) (day) (year)

(c) Cemetery or crematory East Prospect

Location Lower Windsor, Pa.

16 (a) Funeral director Wm. J. Tickner & Sons

(b) Address Balto. MD.

NOV 8 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1948 at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2 1948 to 11/6 1948.
and that I last saw h alive on 11/4 1948.

Immediate cause of death (1) Terminal uremia, secondary to (2).

Due to (2) Probable Kimmelstiel-Wilson syndrome

Due to Diabetes mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman E Thaeler M. D.

Address Johns Hopkins Hospital Date signed 11-7-48

VS 150

68362

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 68362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 Abbott Court
(c) Hospital or institution: 10-0

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 108 Abbott Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph L. Werner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Color or race: White | 5. Sex: Male | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Anna B. Werner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 1869

8. AGE: Years 79 | Months 4 | Days 20 | If less than one day hr. min. 19

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Elsa Spitz
(b) Address 2028 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road & Miller Lane

18 (a) Funeral director John C. Miller Inc
(b) Address 2435 E. Oliver St

19 (a) NOV 8 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10, 1948 to Nov 4 1948 and that I last saw him alive on Nov 2 1948

Immediate cause of death: Coronary Occlusion — Duration: 1 day
Due to:
Due to: Auricular Fibrillation — 11 mos.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph Pokorny M.D.
Address 2201 E Madison St Date signed 11/5/48

VS 150

668363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 668363

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Allendale Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry L. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1890

8. AGE: Years	Months	Days	If less than one day
58	4	4	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Druggist

11. Industry or business

FATHER
12. Name Littleton P. Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Florence L. Harry
15. Birthplace Va

16 (a) Informant Mr Stuart L. Brown,
(b) Address Upper Marlboro, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn, 11/9/48
Location Woodlawn, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 NOV 8 - 1948 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6 1948, at 5:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1948, to 11-6 1948, and that I last saw him alive on 11-6 1948.

Immediate cause of death Respiratory failure — Duration

Due to pneumonia

Due to congestive Heart failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. L. J. Finkell M. D.
Address Franklin Sq. Hospit Date signed 11-6-48

VS 153

668364

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47

668364 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1918 E. Madison St.
(c) Hospital or institution: 7-05
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GUSTAV KOEHLER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Apr. 15, 1875

8. AGE: Years	Months	Days	If less than one day
73	6	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Cabinet Maker Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Jane Jenkins
(b) Address 1918 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore County, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 8 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1948 at 5 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1948 to 11/6 1948, and that I last saw him alive on 11/4 1948.

Immediate cause of death: Uremia Duration

Due to Carcinoma of bladder

Due to " " prostate

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 4/48

Major findings of operation: Carcinoma of prostate

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature A. H. Hornstein M.D.
Address 1042 Bradley Blvd Date signed 11/6/48

VS 150

68365

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

668365
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 934 Montpelier St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 934 Montpelier St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES A. G, LEONARD

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	216-03-9846

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Caroline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1882

8. AGE: Years	Months	Days	If less than one day
65	10	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Interior Decorator
11. Industry or business

FATHER
12. Name Paul Leonard
13. Birthplace Unknown

MOTHER
14. Maiden Name Margaret Melzger
15 Birthplace Unknown

16 (a) Informant Robert J. Leonard
(b) Address 934 Montpelier St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) NOV 8 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948, at 7:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1948 to Nov 5 1948, and that I last saw him alive on Nov. 4 1948.

Immediate cause of death Carcinoma of Descending Colon — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Oct 28 1948
Major findings of operation: Carcinoma of Large Bowel
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward B Wolfe, M.D.
Address 1331 Chatsworth Date signed 11-6 1948

VS 150

68366 BALTIMORE CITY HEALTH DEPARTMENT X ✓ 68366

CERTIFICATE OF DEATH 45F

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Dr. & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town Poplar Bluff
(If outside city or town limits, write RURAL and give town)
(d) Street No. 641 Lindsey St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence William LAMEY

3 (b) If veteran, name war none

3 (c) Social Security Account No. ?

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ruth Lamey

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Jan 16, 1907

8. AGE: Years 41 | Months 10 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Miss.
(Town, county, and state)

10. Usual Occupation Oiler

11. Industry or business Seafarer

FATHER
12. Name William Lamey
13. Birthplace Miss

MOTHER
14. Maiden Name Betty Hopkins,
15. Birthplace Texas

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (b) Date thereof 11/7/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Poplar Bluff
Location Missouri

18 (a) Funeral director Wm Cook Dne
(b) Address 1217 St Paul St

19 (a) Nov 9 1948 Washington Williams Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7, 1948, at 12:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3, 1948 to Nov 7 1948, and that I last saw him alive on Nov. 7 1948.

Immediate cause of death Carcinoma of left tonsil with extension to left neck — **Duration**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:

of autopsy: as above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. C. Robertson M.D.
W. C. Robertson M. D.
Address US Marine Hospital Date signed 11/7/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668367 WIRTH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

668367 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.A.
(b) Street address 3413 Guilford Terrace
(c) Hospital or institution: 17-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Guilford Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret F. (Smith) Wirth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Conrad

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15 1863

8. AGE: Years	Months	Days	If less than one day
85	2	22	hr. min

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name (Johnny) (Frantz) Boals
13. Birthplace Germany

MOTHER 14. Maiden Name Marie Kuppert
15. Birthplace Germany

16 (a) Informant Margaret F. Wirth
(b) Address 3413 Guilford Terrace

17. Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Milton Long
(b) Address 1219 E. Pratt St

19 (a) NOV 8 1948 (Date rec'd by Registrar) (b) Funeral Home Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1948 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. A. Friedman M.D.
Medical Examiner.
Date signed 11/7/48

VS 181

68368 ✓ 68368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4048 Hilton Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 4048 Hilton Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: Fern Sophia Fulverman

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 212-18-4481

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 5, 1895

8. AGE: Years	Months	Days	If less than one day
53	8	1	hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation:
11. Industry or business: Clerk

FATHER
12. Name: Max Fulverman
13. Birthplace: Poland

MOTHER
14. Maiden Name: Bloma Klein
15. Birthplace: Poland

16 (a) Informant: Mr David M Klein
(b) Address: 3407 Springdale Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory: Huntington W Va
Location: W Va

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) NOV 8 1948 (b) Huntington Williams, M.D. Registrar
(Month, day, year) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 6 1948, at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6 1946 to 11-6 1948, and that I last saw h alive on 11/6 1948.

Immediate cause of death: Carcinoma of Breast — Duration: 18 months

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Edwin B Frost
Address: 330 Eutaw St Date signed: 11/6/48

VS 150

68369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. 68369

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 N. Mount Street
(c) Hospital or institution: 19-02
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 N. Mount Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Percy Mc Dowan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Helen Mc Dowan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 31, 1883

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65	-	4		

9. Birthplace West River, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unk.
13. Birthplace

MOTHER
14. Maiden Name Unk.
15. Birthplace

16 (a) Informant Helen Mc Dowan
(b) Address 103 N. Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 - 8 - 48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore, County

18 (a) Funeral director Pearce L.A. Gibbons
(b) Address 5 Druid Hill Ave.

19 (a) NOV 8 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1948 at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 - 2 - 1948 to 11 - 4 - 1948. and that I last saw h in alive on 11 - 3 - 1948.

Immediate cause of death Uremic coma
Cirrhosis Liver

Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Jackson M. D.
Address 600 N. Arlington Ave. Date signed 11 - 6 - 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G68370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1062

G68370 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2838 Linkford Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 7 years

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County
(c) City or town Hackettstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 77 Main St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Wallace Bates

3 (b) If veteran, name war: Yes

3 (c) Social Security Account No. 137-34-3170

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife: No

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1-9-1918

8. AGE: Years	Months	Days	If less than one day
30	9	28	____ hr. ____ min.

9. Birthplace Montpelier - Vermont.
(Town, county, and state)

10. Usual Occupation Fire Keeper

11. Industry or business State

FATHER
12. Name Edward K. Bates
13. Birthplace Vermont

MOTHER
14. Maiden Name Harriet Scott
15. Birthplace Canada

16 (a) Informant
(b) Address

17 (a) Removal (b) Date thereof 11-8-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hackettstown Cemetery
Location Hackettstown N. J.

18 (a) Funeral director Earl B. Robertson-Rice
(b) Address 407 E. 26th St.

19 NOV 8 - 1948 (Date rec'd by registrar) (b) Huntingdon Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1948 at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to Nov 7 1948 and that I last saw him alive on Nov 7 1948

Immediate cause of death	Duration
Acute congestion pulmonale	15 min
Due to Bronchial asthma Emphysema	25 yr.
Due to	
Other Conditions Bronchiectasis	10 yr.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M.D.
Address 11 W. 29th St Date signed Nov 8 48

VS 150

112

68571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. 68571

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. 1803
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 Poppleton St. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Philip A. McGraw

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Sarah C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-31-83

8. AGE: Years	Months	Days	If less than one day hr.	min.
64	10	6		

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Machinist Helper
11. Industry or business Retired

FATHER
12. Name Philip McGraw
13. Birthplace Balto MD.

MOTHER
14. Maiden Name Mary Madigan
15. Birthplace Ireland

16 (a) Informant Sarah C. McGraw
(b) Address 425 Poppleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)
(c) Cemetery or crematory Mayr Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.

19 (a) [redacted] (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6 19 48 at 9 35/A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 19 48 to 11-6 19 48.
and that I last saw h[redacted] alive on 11-6 19 48.

Immediate cause of death	Duration
Cardiac failure	
Due to Chronic portal Cirrhosis	
Due to Malnutrition Chronic Alcoholism	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury
23. Signature H. Bowers Jr. M. D.
Address Mercy Hospital Date signed 11-6-48

VS 150

G68372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

G68372

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Brendon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Brendon ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew John Mc Cart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, ~~divorced~~
M	W	Widowed

6 (b) Name of husband or wife Mary Mc Cart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21-1879

8. AGE: Years	Months	Days	If less than one day
69	8	16	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace

MOTHER
14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Mrs Edward Mayorga
(b) Address 2803 Brendon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Von J. Hoyt & Son
(b) Address 3001 Kentucky ave

19 (a) NOV 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar, M.D. Address 3400

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948, at M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 10 1947, to Nov 5 1948 and that I last saw h alive on Nov 5 1948.

Immediate cause of death Acute Heart failure.
Due to Arteriosclerotic Cardio-Vascular disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L B Stevens Col
Address 3400 Edmondson Date signed 11/9/48

VS 154

668373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

668373 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1918 No Payson St
(c) Hospital or institution: 1504

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 No Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sarah Sklar

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 68 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Chasha
15. Birthplace Russia

16 (a) Informant David Sklar
(b) Address 1918 No Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-48 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 NOV 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7- 1948 at 9:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 7 1948 and that I last saw h[illegible] alive on Nov 7 1948.

Immediate cause of death: Chronic hypertrophic cardiosclerosis — Duration: unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Lashman M.D.
Address 1421 W North Ave Date signed 11/9/48

VS 150

68374 ✓ G68374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address. MONUMENT ST

(c) Hospital or institution: SINAI HOSPT 3 01

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County .....

(c) City or town BALTO

(If outside city or town limits, write RURAL, and give town)

(d) Street No. TEMPLE Gooden 9pts 403 A

(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) **FULL NAME** Leon Schmastzman

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife SHEBY

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5 6 2

8. AGE: Years	Months	Days	If less than one day
56			hr. ..... min.

9. Birthplace NEW ORLEANS (Town, county, and state)

10. Usual Occupation MFG

11. Industry or business

FATHER

12. Name HARRY

13. Birthplace NEW ORLEANS

MOTHER

14. Maiden Name MATHILDA

15. Birthplace NEW ORLEANS

16 (a) Informant WIFE

(b) Address .....

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-9-48 (month) (day) (year)

(c) Cemetery or crematory ARLINGTON

Location ROGERS AVE

18 (a) Funeral director Jack Levin Inc

(b) Address 2100 Eutaw Place

19 NOV 8 - 1948 Washington Williams, Mgr

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7-1948 at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20-1948 to 11-7-1948.

and that I last saw him alive on 11-7-1948

Immediate cause of death	Duration
Acute myocardial infarction	
Due to Coronary sclerosis	
Due to Arteriosclerosis	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....

(Specify type of place)

(e) Means of injury .....

23. Signature J. E. Hamm M. D.

Address Sinai Hospital Date signed 11-7-48

VS 150

X

G68375

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 937

Registered No. G68375

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501-S. Pulaski St.
(c) Hospital or institution:

10-03

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501-S. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE W. ROSS.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	Married.

6 (b) Name of husband or wife Estella L. Ross.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12-1869

8. AGE: Years	Months	Days	If less than one day
78	10	24	hr. min.

9. Birthplace Virginia.
(Town, county, and state)
10. Usual Occupation Foreman. (Retired)
11. Industry or business Arundel Corp.

FATHER
12. Name Charles C. Ross.
13. Birthplace New York.

MOTHER
14. Maiden Name Sarah Hatley.
15. Birthplace Virginia.

16 (a) Informant Miss Mary Calvert.
(b) Address 501-S. Pulaski St.

17 (a) Burial - (b) Date thereof Nov. 8-48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Good Shepherd Cem.
Location Rossland, Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512-Frederick Ave.

19 (a) Nov 8 - 1948 (b) Registrar for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5- 1948. at 10.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1- 1948. to Nov. 5- 1948. and that I last saw h[illegible] alive on Nov. 5- 1948.

Immediate cause of death	Duration
Arteriosclerotic cardio-vascular disease	5 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Hall M. D.
Address 2030 Walbert Ave. Date signed 11-9-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

668:576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

668:576
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Lawrence St
(b) Street address 546 ~~Lawrence St~~
(c) Hospital or institution: 1407

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 545 Lawrence St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/12

8. AGE: Years	Months	Days	If less than one day
36	4	19	hr. min.

9. Birthplace Rocky Mt NC
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Wm Simons
13. Birthplace NC

MOTHER
14. Maiden Name Arenia King
15. Birthplace NC

16 (a) Informant Wm Simons
(b) Address 1917 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Wm A Jackson
(b) Address 916 Penna Ave

19 Nov 8 1948 Registrar Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/48 19 at 1 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/1/48 to 11/4/48 and that I last saw h[illegible] alive on 11/4/48.

Immediate cause of death Cerebral Hemorrhage (a) Duration

Due to Hypertensive

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Davis
Address 113 Harlem Ave (Date signed) 11/7/48

VS 150

68377 MAITH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12B

Registered No. 68377

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address HARFORD ROAD & HERRING RUN
(c) Hospital or institution:
SYDENHAM HOSPITAL 18 01
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 W. Saratoga St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME BRENDA MAITH

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-1-41

8. AGE: Years	Months	Days	If less than one day
7	5	0	— hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation SCHOOLGIRL

11. Industry or business —

FATHER
12. Name WARREN MAITH
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name LORETTA ROBINSON
15. Birthplace BALTIMORE, Md

16 (a) Informant Warren Maith (Father)
(b) Address 823 W. Saratoga St

17 (a) Burial (b) Date thereof 11/8/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles L. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) NOV 8 - 1948 (b) Thurlington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1948 at 8:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1948 to Nov. 6 1948 and that I last saw her alive on Nov 6 1948.

Immediate cause of death	Duration
TUBERCULOUS MENINGITIS	3 weeks
Due to MILIARY TUBERCULOSIS	6 weeks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William E Coot M. D.
Address Sydenham Hosp Baltimore MD Date signed 11/8/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 190

68:578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 68:578

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5603 Carter Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5603 Carter Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard M. Norris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Minnie A.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 13, 1876

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72	5	23		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation retired R.R.Man
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Howard R. Norris
(b) Address 5603 Carter Avenue #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-48 (month) (day) (year)
(c) Cemetery or crematory Lorrane Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Filed by [illegible] (year) (b) Huntington Williams, M.D. Registrar

NOV 8 - 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1948 at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1948, to Nov. 5 1948 and that I last saw h[illegible] alive on Nov 3rd 1948

Immediate cause of death: Cerebral Apoplexy — Duration: 0

Due to: Hypertension Arterio-sclerosis — Duration: years

Due to: Vascular disease — Duration: 1 year

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature H. G. Norris M. D.
Address 5716 Rokeby Rd Date signed 11-8-48

G68379 1079 11657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

Registered No. G68379

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16-07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 Whatcoat St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DANIEL Bernard WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	3		hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George R. Wilson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Viola Banks
15. Birthplace Balto. Md.

16 (a) Informant Viola Banks
(b) Address 1103 Whatcoat St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cemetary
Location Baltimore Md

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Mount St.

19 NOV 8 1948 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1948 at 8:15AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status thymicolymphaticus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11/6/48

VS 151

668380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 668380

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Green Sts

(c) Hospital or institution: University

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1331 North Calhoun St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-10-9057

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Jannie Simmons

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1908

8. AGE: Years	Months	Days	If less than one day
40	4	5	hr. min.

9. Birthplace Winnsboro Fairfield S.C. (town, county and state)

10. Usual Occupation Laborer

11. Industry or business Canton R.R. Co

FATHER

12. Name Will Simmons

13. Birthplace Winnsboro South Carolina

MOTHER

14. Maiden Name Mary

15. Birthplace Winnsboro South Carolina

16 (a) Informant Jannie Simmons

(b) Address 1331 North Calhoun Street

17 (a) (Burial, cremation, or removal) (b) Date thereof November 0, 1948 (month) (day) (year)

(c) Cemetery or crematory Winnsboro South Carolina

Location Fairfield County

18 (a) Funeral director Joseph A. Civicky

(b) Address 66 West Base Street

19 (a) Nov 8 1948 (Date received by Registrar) (b) Huntington Indiana, Ind.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1948 at 4 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 1 1948 to Nov 6 1948 and that I last saw h[illegible] alive on Nov 5 1948

Immediate cause of death: Generalized Carcinomatosis — Duration

Due to probably primary in stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at A M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank E. Slemback M. D.

Address University Hosp Date signed 11/6/48

VS 150

68381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 68381

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Baltimore~~ Baltimore Co.
(c) City or town ~~Baltimore~~ 6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Brookwood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Mc Hale (THOMAS P. McHALE)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary A Kelly | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 12/21/1882

8. AGE: Years: 65 | Months: 10 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation: Retired
11. Industry or business: B & Ohio R.R.

FATHER
12. Name: William Mc Hale
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Hanora Kelly
15. Birthplace: Ireland

16 (a) Informant: Mrs Mary Mc Hale
(b) Address: 604 Brookwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: 801 Fulton Ave

18 (a) Funeral director: J. J. Tobin & Sons
(b) Address: 131 Light St.

19 (a) NOV 8 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5/1948 at 8 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/5/1948 to 11/6/1948, and that I last saw him alive on 11/5/1948

Immediate cause of death: CARDIO RESPIRATORY FAILURE — Duration

Due to: CEREBRAL VASCULAR ACCIDENT

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Shaw M. D.
Address St. Agnes, Md. Date signed 11/6/48

VS 150

668382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

668382 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Neale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1868

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Neale
13. Birthplace

MOTHER
14. Maiden Name Mary Bugan
15. Birthplace

16 (a) Informant Sister-in-law The Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wedefield
(b) Address 900 East Biddle St

19 (a) NOV 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1948, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to Nov 6 - 1948, and that I last saw him alive on Nov 4 - 1948

Immediate cause of death	Duration
Edema Lungs	days
Due to Cerebral Arterio-Sclerosis	4 yrs
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E. North ave Date signed 11/8/48

VS 150

668383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 668383

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or Institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1752 Homestead St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Born in Italy

3 (a) FULL NAME Simone Fortunato

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-14-5540

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) AUGUST 4 1880

8. AGE: Years	Months	Days	If less than one day
68 67	3	2	hr. min.

9. Birthplace CASAMASSIMA - BARI - ITALY (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name GIUSEPPE FORTUNATO
13. Birthplace ITALY

MOTHER
14. Maiden Name Isabella ?
15. Birthplace ITALY

16 (a) Informant: LENA MANFREDO
(b) Address 1752 HOMESTEAD ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 9 1948 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR RD, BALTIMORE MD

18 (a) Funeral director Frank Della Vecchia
(b) Address 322 S. High St.

19 (a) NOV 8 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1948 at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1948 to Nov 6 1948 and that I last saw him alive on Nov 6 1948

Immediate cause of death	Duration
Pulmonary Edema	
Due to Myocardial Insufficiency	
Due to Enteric Infection Head & Neck	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Guy E. Renzo Jr. M.D.
Address 1 E. Franklin St. Date signed 11/6/48

VS 150

G68384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. G68384

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fulton & Caton Aves.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hr.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 29 (If outside city or town limits write RURAL and give town)

(d) Street No. 36 Overbrook Rd. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Dorothy G. Callahan

3 (b) If veteran, name war

3 (c) Social Security Account No.

~~4. Sex~~ Female

5. Color or race White

6 (a) Single, married, widowed or divorced. Married

6 (b) Name of husband or wife John B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-3-1894

8. AGE: Years 54 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Robert S. Greene (dec.)

13. Birthplace Ohio

MOTHER 14. Maiden Name Flora Lee (dec.)

15. Birthplace Md.

16 (a) Informant John B. Callahan

(b) Address 36 Overbrook Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8 1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Baltimore

18 (a) Funeral director Frederick A. Cohen

(b) Address 2240 W. Lombard St.

NOV 8 1945 Huntington, Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 1945 at 2:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1945 to 11-5 1945 and that I last saw h[illegible] alive on 11-5 1945.

Immediate cause of death Cardiac failure

Due to Rheumatic c.v. disease with

Due to a) mitral stenosis

b) Chronic auricular fibrillation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Sidney Johnson Venable M.D.

Address St. Agnes Hospital Date signed 11-5-45

VS 150

G68385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43

Registered No. G68385

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 Days.
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 262 S. East Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Robier, Mrs. Frances Jane (Graibel)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3/29/85.

8. AGE: Years	Months	Days	If less than one day
63.	7	9	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15 Birthplace

16 (a) Informant Benjamin Robier
(b) Address 262 S. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Caton Ave & Gor

18 (c) Funeral director Lilly & Zeck
(b) Address 403 N. Eutaw St.

19 (a) NOV 8 1948 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1948 at 7 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1948 to 11/7 1948 and that I last saw her alive on 11/7 1948.

Immediate cause of death: Cardio-Respiratory Failure — Duration
Due to Meningitis due to Torula Histolytica.
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature John T. Emmett, M.D.
Address St. Josephs Hosp Date signed 11/7/48 M. D.

VS. 150

G68386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G68386

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Pk. Dr. & 31st St.

(c) Hospital or institution:

U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 32

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2329 E. Chase Street (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Daniel Funk

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Veronica Funk

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1898

8. AGE: Years	Months	Days	If less than one day
50	8	20	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business Automobile

FATHER

12. Name John W. Funk

13. Birthplace Md.

MOTHER

14. Maiden Name Mary L. Myers

15. Birthplace Md.

16 (a) Informant Records

(b) Address US MArine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)

(c) Cemetery or crematory Balto. National

Location Frederick Rd. Balto. Md.

18 (a) Funeral director Lilly and Zeiler, Inc.

(b) Address 403 S. Wolfe St. Balto. Md.

19 (a) NOV 8 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7, 1948 1948 at 12:30a M

21. I certify that death occurred on the date above stated: that I attended deceased from Oct 6 1948 to Nov 7 1948, and that I last saw him alive on Nov 7 1948.

Immediate cause of death: Carcinoma of upper lobe of right lung with metastases — Duration: unkn

Due to

Due to

Other Conditions Bronchopneumonia, lower lobe of left lung. — Duration: 577 da

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. C. Robertson M.D. W. C. Robertson M. D.

Address US MArine Hospital Date signed 11/7/48

VS 190

Please write plainly, with INDELIBLE INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68387

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 68387

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County York,
(c) City or town Hanover (If outside city or town limits write RURAL and give town)
(d) Street No. 9 Sprenkle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Fuhrman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Robert

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr) 4-23-03

8. AGE: Years 45 | Months 6 | Days 13 | If less than one day: hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name James Straubaugh
13. Birthplace Pa

MOTHER 14. Maiden Name Dava Fink
15. Birthplace Pa

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 10 1948 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Mechanicstown Pa

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 (a) NOV 8 1948 (b) Signature rec'd by registrar Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1948, at 11 05A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1948 to 11/6 1948 and that I last saw her alive on 11/6 1948.

Immediate cause of death (1) Shock, etiology undetermined — Duration

Due to (2) Hypertensive Vascular Disease

Due to (3) Bilateral thrombus appendectomy, recent

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman E. Thaler M. D.
Address Johns Hopkins Hospital Date signed 11-7-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 93D

G68388 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Avenue
(c) Hospital or institution: 5 c 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 St. Matthews St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Adeline Brinkley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widow

6 (b) Name of husband or wife Ezekiah Brinkley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1896

8. AGE: Years	Months	Days	If less than one day
52	0	3	hr. min.

9. Birthplace Raleigh, N.C. (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Emma O'Neil
15. Birthplace N.C.

16 (a) Informant Mrs. Virginia Jackson
(b) Address 1206 St. Matthews St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cem.
Location Baltimore Md.

18 (a) Funeral director Charles B. Law
(b) Address 802 Madison Ave.

19 (a) NOV 8 - 1948 (Date rec'd by registrar) (b) Lexington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1948 at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1948 to Nov. 4 1948.
and that I last saw h[illegible] alive on Nov. 4 1948.

Immediate cause of death	Duration
Uremia	3 wks
Due to Hypertension	
Due to Cardio Vascular Renal Disease	
Other Conditions Cystitis	
Influenza	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 11/7/48

VS 150

668389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 668389

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2569 W. Lombard St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2569 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) —
If yes, name country

3 (a) FULL NAME Frederick C. Leitzman

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-12-0163

4. Sex M. **5. Color or race** W **6 (a) Single, married, widowed, or divorced.** Married

6 (b) Name of husband or wife Annie M.

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr) July 17 1881

8. AGE: Years 67 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name Otto Leitzman
13. Birthplace Germany

MOTHER
14. Maiden Name Selma Gebhardt
15. Birthplace Germany

16 (a) Informant Mrs Annie Leitzman
(b) Address 2569 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Nov. 10. 48 (month) (day) (year)
(c) Cemetery or crematory Immanuel
Location Linden Lane

18 (a) Funeral director L. HEEMANN & SON
(b) Address 6067 HARFORD Rd.

19 (a) NOV 8 1948 **(b)** Huntington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7. 1948, at 2:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1946 to Nov 7 1948, and that I last saw h[illegible] alive on Nov 7 1948

Immediate cause of death
1 - Acute Pulmonary edema — Duration 2 hours
Due to 2 - Chronic nephritis with hypertension — 6 years
Due to
Other Conditions Cerebral Hemorrhage — 4 days
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Rocemini, M. D.
Address 206 S. Gilmor St. Date signed 11-8-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

68390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68390

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4508 Luerssen Ave.
(c) Hospital or institution: 21 of
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4508 Luerssen Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLINE LUERSSEN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Charles F. Luerssen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7th, 1872

8. AGE: Years	Months	Days	If less than one day
76	4 3	29	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George Lieber
13. Birthplace Germany

MOTHER
14. Maiden Name Christiana Shock
15. Birthplace Germany

16 (a) Informant Rev. C.A. Luerssen
(b) Address 4506 Schley Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)
(c) Cemetery or crematory Immanuel Lutheran
Location Baltimore, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 [illegible] 8-1948 (b) Tuntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6th, 19 48, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 19 48 to 11-6 19 48
and that I last saw h er alive on 19

Immediate cause of death Arteriosclerotic Cardiovascular disease — Duration unable to state

Due to Chronic Myocarditis — 3 hrs.

Due to Acute Heart failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature 10 W. Madison St. M. D.
Address Date signed 11-9-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

68391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 68391

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4404 Springdale Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 4404 Springdale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS PARTIN ROBERTSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Bertha Thiele
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/24/61

8. AGE: Years	Months	Days	If less than one day
87	7	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Auto Accessories
11. Industry or business

FATHER
12. Name William George Robertson
13. Birthplace Rockville, Md.

MOTHER
14. Maiden Name Victorine Scott
15. Birthplace —

16 (a) Informant Alice R. Abbott
(b) Address 4404 Springdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Ernest Arnacost
(b) Address 3911 Liberty Heights Ave.

19 (a) NOV 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to 11-6 1948, and that I last saw h— alive on 11-6 1948.

Immediate cause of death: Coronary Occlusion — Duration 1 hr

Due to: Generalized Arteriosclerosis — 15 yrs

Due to: Hypertension — 10 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Dr Thos P Abbott

Address 4404 Springdale Date signed 11-7-48

VS 150

G68392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G68392 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 862 W. Fayette St.
(c) Hospital or institution: 1801
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits write RURAL and give town)
(d) Street No. 862 W. Fayette (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 25, 1907

8. AGE: Years: 41 | Months: 7 | Days: 12 | If less than one day: hr. min

9. Birthplace: Johnson County N. C. (Town, county, and State)

10. Usual Occupation: Housewife

11. Industry or business

MOTHER / FATHER

12. Name: Lonnie Penny

13. Birthplace: Johnson Co. N.C.

14. Maiden Name: Fredilia Turner

15. Birthplace: Johnson Co. N.C.

16 (a) Informant: Frank Jones

(b) Address: 862 W. Fayette St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof November 8, 1945 (month) (day) (year)

(c) Cemetery or crematory: Raleigh

Location: North Carolina

18 (a) Funeral director: Mrs Katie R. Williams

(b) Address: 322 N. Schroeder St

19 (a) NOV 8 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1945, at 4:38 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1945 to Nov 6 1945 and that I last saw [illegible] alive on Oct 25 1945

Immediate cause of death: Cardiac Failure — Duration

Due to: Valvular Heart Disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Douglas Sheppard M.D.

Address: 604 N. Dulaney Date signed 11/5/45

VS 133

G68393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68393

Registered No. 931

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2127 Vine St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 Vine St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Joseph Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Celia Mannion
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 16, 1872

8. AGE: Years	Months	Days	If less than one day
76	7	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant John J. Robinson, Jr.
(b) Address 2127 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A Farley
(b) Address Fulton ave & Fayette St

19 (a) NOV 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1948, at 12:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Nov 7 1948, and that I last saw h[illegible] alive on 11/6 1948.

Immediate cause of death: Arteriosclerotic Cerebral Disease — Duration 5 yrs

Due to

Due to

Other Conditions Hypertension — 4 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Robinson Jr.
Address 1546 W Balt St Date signed 11/7/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G68:594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G68:594
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 341 South Chester St.
(c) Hospital or institution: 1-C-S

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 341 S. Chester St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Lawrence Walsh

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Genevieve O'Connell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/6/ 1883

8. AGE: Years	Months	Days	If less than one day
65	3	1 0	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Patrolman
11. Industry or business

FATHER
12. Name John Walsh
13. Birthplace

MOTHER
14. Maiden Name Mary Elizabeth Dougherty
15. Birthplace

16 (a) Informant William J. Walsh
(b) Address 2028 Bait St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9, 48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4900 Frederick Road

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Baltimore 31, Md.

19 (a) NOV 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 6 1948, at 4.47 AM

21. I certify that death occurred on the date above stated; that I attended deceased from OCT 22 1948 to NOV 6 1948, and that I last saw h(im) alive on NOV 6 1948.

Immediate cause of death BRONCHO-PNEUMONIA — Duration 12 DAYS
Due to CHRONIC MYOCARDITIS
Due to
Other Conditions ARTERIOSCLEROSIS
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

(P)
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature James F Kavanagh M.D.
Address 301 McCulloh St Date signed 11-8 48

VS 150

92)

668395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

668395 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mount St.
(c) Hospital or institution: Sinai 1-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 614 S. Rose St. (If outside city or town limits, write RURAL and give town)
(d) Street No. Balto Md (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Dembeck

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	married

6 (b) Name of husband or wife August
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1917

8. AGE: Years	Months	Days	If less than one day
31			hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name William Lorek
13. Birthplace Balto

MOTHER
14. Maiden Name Helen Kozlowska
15. Birthplace Balto

16 (c) Informant August Dembeck
(b) Address 614 S. Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Govans Hill Rd

18 (a) Funeral director Duffy & Zeth Inc
(b) Address 403 S. Wolfe St

19 (a) (Date received) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1948 at 11:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-8 1948, to 11-7 1948, and that I last saw her alive on 11-7 1948.

Immediate cause of death Uremia — Duration

Due to Chronic glomerulonephritis

Due to

Other Conditions Bronchopneumonia
Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place).
(d) Means of injury

23. Signature Jerome Gaber M. D.
Address Sinai Hosp. Date signed 11-8-48

X

G68396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G68396

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2510 Roslyn Ave.

(c) Hospital or institution: 15-08

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2510 Roslyn Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JANYE C. KONOW

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Harry C. Konow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 23, 1890

8. AGE: Years	Months	Days	If less than one day
58	9	13	hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)

10. Usual Occupation Seed Analyst (retired)

11. Industry or business J. Bolgiano & Son

FATHER

12. Name John T. Shipley

13. Birthplace Md.

MOTHER

14. Maiden Name Matilda Thompson

15 Birthplace Md.

16 (a) Informant Mr. Harry C. Konow

(b) Address 2510 Roslyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) NOV 8 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1948 to Nov 6 1948, and that I last saw h-r alive on Nov 5 1948

Immediate cause of death Carcinoma of Stomach — Duration about 6 mo.

Due to

Due to

Other Conditions Secondary anemia — 2 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature Walter D. Lybatt M. D.

Address 2220 Garrison Blvd Date signed Nov. 7 '48

VS 180

G68397

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68397

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 Clarendon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mayfield W. Veise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, (widowed) or divorced. widowed

6 (b) Name of husband or wife William F. Veise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1889

8. AGE: Years 59 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Samuel J. Widerman
13. Birthplace Woodlawn, Md.

MOTHER
14. Maiden Name Catherine Grill
15. Birthplace Balto. Co., Md.

16 (a) Informant Mr. John J. Veise
(b) Address 2807 Presbury St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE CEM.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. Huntington Williams, M.D.

19 NOV 8 1948 (b) (Date received by local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1948 at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Nov 1948 to 7 Nov 1948, and that I last saw her alive on 7 Nov 1948.

Immediate cause of death: Brain tumor. — Duration: over

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6 Nov 1948

Major findings of operation: Tumor of brain

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jose A Olivery-de Chaudens M.D.
Address University Hospital Date signed 7 Nov 48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G68398

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 North Front Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES Charles O. Griffith GRIFFITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 8, 1882

8. AGE: Years	Months	Days	If less than one day
65 66	11	29	hr. min.

9. Birthplace Berks Co., Pennsylvania
(Town, county, and state)

10. Usual Occupation Sign Painter

11. Industry or business

FATHER
12. Name Jeremiah Griffith
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Amanda Ott
15. Birthplace Pennsylvania

16 (a) Informant Kindt Funeral Home
(b) Address Shillington, Pa.

17 (a) Removal (b) Date thereof 11-8-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Shillington, Pa.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address 1948 Baltimore

19 (a) NOV 8 - 1948 (b) Huntingdon Valley, Pa.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1948, at 7:38 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy / Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Fred L. Rogers M.D.
Medical Examiner.
Date signed Nov 9 48.

VS 151

TB C-48-23923 X ✓ 668399

668399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 668399

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Harlkens × Caton Ave.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs. 5min.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County BALTO.

(c) City or town Baltimore - 29 (If outside city or town limits, write RURAL and give town)

(d) Street No. 802 Buckfield Ave. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Jordan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr) 11-4-48

8. AGE: Years | Months | Days | If less than one day: 2 hr. 15 min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Alfred L. Jordan

13. Birthplace Md.

MOTHER 14. Maiden Name Elsie M. Rufener

15. Birthplace Ohio

16 (a) Informant Alfred L. Jordan

(b) Address 802 Buckfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director MARTIN FAHEY & SONS

(b) Address 1827 W. Lexington Baltimore, Md.

19 (a) Filed 8- 1948 (b) (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/48 19 at 4:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 19 48 to 11/4 19 48 and that I last saw her alive on 11/4 19 48.

Immediate cause of death Miscarriage at 20-22 wks.

Due to

Due to Premature

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Virgil Dewese Jr. M. D.

Address St. Agnes Hosp. Date signed 11/5/48

Balto Md ×

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92c

Registered No. 68400

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hosp. 27-1-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 St Agnes Convent Mt Wash. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sr. Mary Jane Frances RSM.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1895

8. AGE: Years	Months	Days	If less than one day
53	1	15	25 hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name T. P. Tibbitts
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Jane Craig
15. Birthplace Maryland

16 (a) Informant Hosp. records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month), (day), (year)
(c) Cemetery or crematory Mt. St. Agnes
Location Mount Washington

18 (a) Funeral director H. C. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) NOV 8 - 1948 (Date rec'd by registrar) (b) Huntington for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1948 at 12 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1947 to Nov. 7 1948 and that I last saw her alive on Nov 6 1948.

Immediate cause of death: Cardiac failure — Duration
Due to: Rheumatic cardio-vascular disease
Due to:
Other Conditions: Narcolepsy

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. Jeannette M.D.
Address Mercy Hosp. Date signed 11/7/48

VS 150

G68401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G68401 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2606 Foster Ave
(c) Hospital or institution: 1-03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Foster Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Walter Page (Wladislaus Paga)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20-1872

8. AGE: Years	Months	Days	If less than one day
76	3	14	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unk.
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Rose Krawczyk
(b) Address 2609 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9-48 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore

18 (a) Funeral director John G. Connelly
(b) Address 416 Eastern Ave.

19 NOV 8 1948 (b) Washington Williams Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7th 1948, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1948, to Nov. 6 1948, and that I last saw him alive on Nov. 6 1948.

Immediate cause of death	Duration
Myocarditis	Unknown
Due to Arteriosclerosis	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury Ferdinand R. Ross

23. Signature

Address 24 S. Bond Date signed 11/8/48

VS 150

5402

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

178a

Registered No. 668402

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 4-07
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 750 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME RUDOLPH HICKS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
65			..... hr. ..... min.

9. Birthplace U (Town, county, and state)
10. Usual Occupation K
11. Industry or business N U

PARENTS
12. Name O N
13. Birthplace W K

MOTHER
14. Maiden Name N N O
15. Birthplace U N

16 (a) Informant.....
(b) Address.....

17 (a)..... (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory.....
Location University Medical School NOV 8 1948

18 (a) Funeral director Commissioner of Health
(b) Address.....

NOV 8 1948 (Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1948, at 6:15 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxiation due to illuminating gas

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 27, 48 at approx. 5 P.M.
(b) Where did injury occur? Above Address
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury illuminating gas-but unlit oven burner on

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 10/28/48

X

G68403

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68403

1. PLACE OF DEATH:
(a) Baltimore City, Maryland DOA
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 E Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fitzhugh L. Simms (dsm)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1889

8. AGE: Years 59 (dsm) | Months | Days | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Francis M. Simms
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Martha L. Lowe
15. Birthplace: Virginia

16 (a) Informant: Charles P. Simms
(b) Address: 140 McPahil Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-48 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Baltimore, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

(a) NOV 8 1948 (Date rec'd by registrar) (b) Huntington Station, Md. Residence

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6 19 48 at 2:30 P.M. (dsm)

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.
Date signed 11/7/48 (dsm)

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668404 BALTIMORE CITY HEALTH DEPARTMENT 668404
CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: ~~University Hospital~~ Mercy Hospital DO A
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 E. Exeter St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS J. DEVLIN

3 (b) If veteran, name war ——

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary Gorman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 31, 1880

8. AGE: Years 68 | Months — | Days 6 | If less than one day: hr. min.

9. Birthplace (State) Phila., Pa.
(Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name Arthur Devlin
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Boyd
15. Birthplace Ireland

16 (a) Informant W. H. Coleman & Son
(b) Address 4731 Lancaster St., Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Philadelphia, Pa.

18 (a) Funeral director John F. ~~Dem~~ Devany, Inc.
(b) Address 715 Light Street

19 (a) (Signature of registrar) Registrar
(Date received) NOV 8 1948

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1948, at 9:50 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature John R. Devans M.D.
Medical Examiner.
Date signed 11/6/48

3405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 668405

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 Clifton Pk Ter.
(c) Hospital or institution: 8 o 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Clifton Pk Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Thomas Heiger

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-7224

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 1886

8. AGE: Years	Months	Days	If less than one day
62	23	13	14 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Car Inspector

11. Industry or business Penna RR

FATHER
12. Name ?
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace France

16 (a) Informant Katherine E. Heiger
(b) Address 3002 Clifton Pk. Terrace

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11/10/48 (month) (day) (year)
(c) Cemetery or crematory Woodland Cem.
Location Baltimore Co. Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St

19 (a) NOV 5 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1948, at 1 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1948 to Nov 7 1948. and that I last saw h alive on Nov 5 1948.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature W. Gordon

Address 3400 E. Baltimore Date signed 11/8/48 M.D.

VS 150

8406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68406

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1y 6m
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2649 Hampden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA BERDINIA LINS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John G.
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr): Nov. 25, 1868
8. AGE: Years 79 | Months 11 | Days 12 | If less than one day: ____ hr. ____ min.
9. Birthplace: Chicago, Ill (Town, county, and state)
10. Usual Occupation: Houdewife
11. Industry or business

FATHER
12. Name: (Unknown) Lijenberg
13. Birthplace: Sweden

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Sweden

16 (a) Informant: John Lins
(b) Address: 2649 Hampden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory: Mt Olivet
Location: Baltimore, Md.

18 (a) Funeral director: William Cook, Inc
(b) Address: 1217 St. Paul St.

19 (a) NOV 9 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1948 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1948 to 11-7 1948 and that I last saw her alive on 11-6 1948.

Immediate cause of death: Generalized Arteriosclerosis — Duration: 10 yrs
Due to
Due to
Other Conditions: Cerebral Hemorrhage — 2 yrs
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature: Norman R Klemm
Address 3803 Edmondson Ave Date signed 11/8/48

VS 150

8107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 85

Registered No. 668107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General 16-06
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 934 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie A. HORSEMAN

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: David Horseman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1901

8. AGE: Years: 47 | Months: 1 | Days: 22 | If less than one day: hr. min.

9. Birthplace Taylor's Island, Md. (Town, county, and state)

10. Usual Occupation Home

11. Industry or business Home

FATHER
12. Name Frank Spurry
13. Birthplace Md.

MOTHER
14. Maiden Name Virgie Burak
15. Birthplace Md.

16 (a) Informant: Mrs. Nina Anzmann
(b) Address 934 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. ms.

18 (a) Funeral director JOHN T. STANSBURY
(b) Address 2700 Edmondson Ave.

NOV 9 - 1948 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1948, at 7:06 AM

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Epilepsy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 11/8/48

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

73a

G68408 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St

(c) Hospital or institution: Baltimore Md 11-04

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 442 Edmondson Court (If rural give location)

(e) Citizen of foreign country? Yes (Yes or No) If yes, name country

3 (a) FULL NAME Nellie Campher Conway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female Negro

5. Color or race

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/3/1892

8. AGE: Years 45 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name William Campher

13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Brown

15. Birthplace Md

16 (a) Informant Mrs Susie Campher

(b) Address 818 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Baltimore, Md

18 (a) Funeral director Mrs Frances A. Hemphill

(b) Address 518 W. Biddle St.

19 (a) NOV 9 - 1946 (Date rec'd by Registrar) (b) Thomas Washington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6 1946, at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1942, to 11-6 1946, and that I last saw h~~er~~ alive on 11-4 1946.

Immediate cause of death Pneumonia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 11-8-46

VS 150

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 Pittman Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: WILLIAM JAMES HARRISON

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 216-07-0087

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence Emma

6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr): Feb. 5, 1873

8. AGE: Years: 75 | Months: 9 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Harford County, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business: Waverly Press, Inc.

FATHER
12. Name: George Harrison
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Jane Hitchecke
15. Birthplace: Maryland

16 (a) Informant: Mrs. Florence C. Harrison
(b) Address: 433 Pittman Place - 2

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/10/48 (month) (day) (year)
(c) Cemetery or crematory: St. Pauls Meth. Church Cem.
Location: Harkins, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 NOV 9 - 1948 (Date rec'd by Registrar) (By) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1948 at 2.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1948 to 11-8 1948. and that I last saw h/M alive on 11-8 1948.

Immediate cause of death: Duodenal ulcer

Due to: Bleeding

Due to: erosion of the ulcer.

Other Conditions: Arterio Vascular accident.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ulcer of the duodenum

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Albert C. Herrmann M. D.

Address: West Balto Gen Hosp Date signed: 11-8-48

VS 150

1176

3410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 668410

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE & John ST
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 67

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hopkins apt - St Paul & 31st St
(If rural give location)
(e) Citizen of foreign country? No - (Yes or No)
If yes, name country

3 (a) FULL NAME Marian Baylies Hines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29 1881

8. AGE: Years	Months	Days	If less than one day
67	6	8	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Henry Hines
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Ella Baylies
15. Birthplace Baltimore Maryland

16 (a) Informant Patient
(b) Address Hopkins Apts.

17 (a) Burial (b) Date thereof 11-10-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave, Balto.

18 (a) Funeral director John F Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place

19 NOV 9 - 1948 (b) Clayton Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1948 at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1948, to Nov 7 1948, and that I last saw h[illegible] alive on Nov 7 1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Congestive Heart Failure	
Due to Myocardial Infarction	6 days
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Findings above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mark S. Hall, M.D.
Address Hosp. Women of Md. Date signed 11/12/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

88411

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 137a

Registered No. 66811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts
(c) Hospital or institution: Mercy Hosp. Hal, Balto.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 01
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN EDWARD STOLL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ada E. Stoll
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr) Nov. 29, 1859

8. AGE: Years	Months	Days	If less than one day
88	11	7	hr. min.

9. Birthplace Anne Arundel Co., Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Daniel Stoal
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Berger
15 Birthplace Maryland

16 (a) Informant Ada E Stoll
(b) Address 3 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Cedar Hill
Location Brooklyn, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 NOV 9 - 1948 (Date rec'd by Registrar) (b) Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1948, at 5:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19 48, to Nov. 7 1948, and that I last saw h.me alive on Nov 7 1948.

Immediate cause of death	Duration
Chronic Cardiac Failure (Contributing)	
Due to Myocardial degeneration	
Due to Coronary sclerosis	
Other Conditions Post operative pneumonia	9 days

(Include pregnancy within 3 months of death)

Date of operation 10-26-48
Major findings of operation: Cancer of rectum
Hypostatic pneumonia & methicillin resistant staph aureus
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert [illegible] M.D.
Address Mercy Hosp. Date signed 11-7-48

VS 189

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 68312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Sykesville (If outside city or town limits, write RURAL and give town)
(d) Street No. Oakland Mills Rd., nr. Liberty Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MILTON M. BENNETT

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-5632

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Feezer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 25, 1902

8. AGE: Years	Months	Days	If less than one day
46	9	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Tree Trimmer
11. Industry or business Gas & Electric Co.

FATHER
12. Name Milton Bennett
13. Birthplace Maryland

MOTHER
14. Maiden Name Mamie Shipley
15. Birthplace Maryland

16 (a) Informan: Mary Feezer
(b) Address Sykesville, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-48 (month) (day) (year)
(c) Cemetery or ~~XXXXXXX~~ Oakland
Location Carroll Co., Maryland

18 (a) Funeral director WEER & SON
(b) Address

19 NOV 9 - 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1948, at 11:30A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured ribs
Laceration of lung.
~~Due to~~ Hemorrhage into chest cavity.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-8-48 at 11:00 A. M.
(b) Where did injury occur? N. side of Liberty Rd. ½ mile west of Ward's Chapel
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Fell from tree-35' to 40'

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11-8-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

Registered No. 668413

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 Walnut Ave
(c) Hospital or institution: 28-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Walnut Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BESSIE P RECTOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1879

8. AGE: Years	Months	Days	If less than one day
69	4	1	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Isaac Renner
13. Birthplace West Virginia

MOTHER
14. Maiden Name Martha -
15. Birthplace -

16 (a) Informant Mr. John W. Rector
(b) Address 1100 Walnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9 '48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson AVE & Longwood St

18 (a) Funeral director Harry H. Wehrle
(b) Address 4101 Edmondson Ave.

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1948, at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to Nov. 1948, and that I last saw h[illegible] alive on 1st Nov. 1948.

Immediate cause of death Uremia — Duration 1 wk.
Due to Congestive heart failure — 18 mos.
Due to Generalized Arteriosclerosis — years
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jesse P. Hamburger Jr M. D.
Address Date signed

VS 150

I hereby certify that the above is a true and correct copy of the original certificate of death now in my custody. Physicians: please write the causes of death clearly and legibly. This copy is especially important.

G68417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G68414

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3705 Edmondson Ave.
(c) Hospital or institution: 20-07
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3705 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE HENRY KULLICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
W.	M	WIDOWED

6 (b) Name of husband or wife late Wilhelmina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 '1858

8. AGE: Years	Months	Days	If less than one day
90	4	9	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Baker

FATHER
12. Name - Kullick
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Herman G Kullick
(b) Address 3705 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9 '48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave & Longwood

18 (a) Funeral director Harry H. Nitzsche
(b) Address 4101 Edmondson Ave.

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/19/ 1947, to 11/6/ 1948 and that I last saw him alive on 11/5/ 1948.

Immediate cause of death: Arteris sclerotic heart disease — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel M. D.
Address 1226 Hanover St. Date signed 11/9/48

VS 150

5415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G68415

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ months
(e) Length of stay in Baltimore (yrs., mos., or days) 52

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 E. 30th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Agnes Markiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/29/95

8. AGE: Years	Months	Days	If less than one day
53 52	1	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Trzcinski
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Malinowski
15. Birthplace Poland

16 (a) Informant Frank Markiewicz
(b) Address 1730 E 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11-1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 200 Eastern ave

NOV 9 - 1948 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1948 at 12:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1948 to Nov 8 1948 and that I last saw her alive on Nov 8 1948.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to Hypertensive Cardio Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify one)
(e) Means of injury

23. Signature Ray E. Pierson Jr. M. D.

Address Date signed

VS 150

8416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. 68416

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Gold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Parkville Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Garden Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Turner A. Raynes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	divorced

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 9, 1872

8. AGE: Years	Months	Days	If less than one day hr.	min.
76	2	28		

9. Birthplace (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Alburn Raynes
(b) Address Garden Ave. Fullerton P.O.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6th 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 19 48 to Nov 6 1948; and that I last saw him alive on Nov. 4 1948

Immediate cause of death: Carcinoma - Sigmoid Colon — Duration: ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Norman R Klemm M.D.
Address 3803 Edmondson Ave Date signed 11/8/48.

VS 150

68417 Hals

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

Registered No. 68417

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 C
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 78 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Hillman Ct (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William M. Hakesley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ella P.

6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) 10-31-69

8. AGE: Years 79 | Months 10 | Days 6 | If less than one day: hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Retired salesman

11. Industry or business

FATHER
12. Name Edward Hakesley
13. Birthplace Maryland

MOTHER
14. Maiden Name Alvista McComas
15. Birthplace Maryland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (c) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6- 1948 at 8:12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1948 to 11-6 1948, and that I last saw him alive on 11-4 1948

CERTIFICATION APPROVED BY

Immediate cause of death Cerebral palsy — Duration

Ed K Rogers M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

Due to Hypostatic pneumonia

Due to Senility, fracture neck of left hip

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: T. B. of lungs

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 10-21-48 at 12 PM
(c) Where did injury occur? Balto (City or town) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) (While at work) no
(e) Means of injury fall slipped on rug fell to floor

23. Signature N K Kerzerian M. D.
Address Johns Hopkins Hosp. Date signed 11-7-48

68218 BC-48-15269

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

64

Registered No. 68218

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DO A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WARDEN ALEXANDER GIBSON, JR.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give [illegible] years

7. Birth date of deceased (mo., day, yr) July 1948

8. AGE: Years	Months	Days	If less than one day
	4	—	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Warden Alexander Gibson, Sr.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Dorothy Wilson Gibson
15. Birthplace Balto., Md.

16 (a) Informant Warden Alexander Gibson, Sr.
(b) Address 1128 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11, 1948
(c) Cemetery or crematory Mt. Zion Am.
Location

18 (a) Funeral director Mrs Katie K. Williams
(b) Address 322 N Schroeder St

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1948 at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Upper respiratory infection.
Status thymico lymphaticus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thos. A. Merrill M.D. Medical Examiner
Date signed 11/8/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. X68419

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2500 Druid Hill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 03
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRISON COOPER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lena Cooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1898

8. AGE: Years 50 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Leesburg, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Alfred Cooper
13. Birthplace Leesburg, Va.

MOTHER
14. Maiden Name Lena Brown Cooper
15. Birthplace Leesburg, Va.

16 (a) Informant Lena Cooper
(b) Address 2500 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10, 1948 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director MRS. KATIE R. WILLIAMS
(b) Address 322 N. Schroeder St.

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Funeral Director

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1948 at 8:30AM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.

Date signed 11/6/48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 1a

Registered No. 668420

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution. University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30hr
(e) Length of stay in Baltimore (yrs., mos., or days) 11 0 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 420 Valley Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irvin West.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Geneva West

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 24, 1909

8. AGE: Years 38 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Centerville Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name A. Harrison West
13. Birthplace Talbot Md

MOTHER 14. Maiden Name Dolly Blake
15. Birthplace Centerville Md.

16 (a) Informant A. Harrison West
(b) Address 1398 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

16 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Nov 1948, at 11 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Nov 1948, to 7 Nov 1948, and that I last saw him alive on 7 Nov 1948.

Immediate cause of death Pneumococcus Meningitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard D Hoover M. D.
Address Univ Hospital Date signed 7 Nov 48

VS 150

68421

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 68421

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address The Warrington Apts.
(c) Hospital or institution: 3908 N. Charles St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 y 6 1
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EILERT HERMAN KOESTER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:
4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: Lisette Koester
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.) Sept. 26, 1855
8. AGE: Years 93 | Months 1 | Days 11 | If less than one day: hr. min.
9. Birthplace Oldenburg, Germany (Town, county, and state)
10. Usual Occupation Chairman of Board
11. Industry or business E. H. Koester Bakery Co.

FATHER
12. Name Gerhard Koester
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Duser
15. Birthplace Germany

16 (a) Informant Mr. William H. Koester
(b) Address 650 W. Lexington St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Mausoleum
Location Pikesville, Md.
18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) Nov. 9 1948 (b) Thurlington Williams, M.D. Registrar
(Date filed by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1948, at 11:00 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 10/2/48 to 11-7-1948
and that I last saw h[illegible] alive on 11-7 1948

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	8 yr.
Due to Uremia Congestive Encephalitis	
Due to Acute heart failure Malignant	14 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Luther E. Little M. D.
Address 10 W. Madison St. Date signed 11-8-48

LUTHER E. LITTLE

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

668422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 668422

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 Denison St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Denison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD WILFRED VOLMAR

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Albina Volmar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 26, 1908

8. AGE: Years	Months	Days	If less than one day
40	0	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Rubber Stamp Mfgs.
11. Industry or business Self

FATHER
12. Name William Volmar
13. Birthplace Balto.

MOTHER
14. Maiden Name Jane Miller
15. Birthplace Eng.

16 (a) Informant Mrs. Albina Volmar
(b) Address 405 Denison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 9 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1948, at 6.55 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1946 to Nov 8 1948.
and that I last saw him alive on Nov. 7 1948.

Immediate cause of death — Duration

Malignancy of Lung — 2 yrs.
Due to (Bronchogenic
Due to Carcinoma
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Nov. 1946
Major findings of operation: Pneumonectomy
Cancer of Bronchus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. W. Jacobs M. D.
Address 2310 Eutaw Place Date signed 11-8-48

VS 130

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68423

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

Registered No. 68423

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1536 Rosedale St.
(c) Hospital or institution: — 16-07
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Balto.
(c) City or ~~town~~ Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1536 Rosedale St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Minnie A. Hoffman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed~~, or divorced: Married

6 (b) Name of husband or ~~wife~~: J. Edw. Hoffman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 9, 1877

8. **AGE:** Years: 71 | Months: 3 | Days: 28 29 | If less than one day: hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mr. J. Edw. Hoffman (Husband)
(b) Address 1536 Rosedale St.

17 (a) Burial (b) Date thereof 11-10-48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Druid Ridge
Location Pikesville, MD

18 (a) Funeral director Wm J. Tickner & Sons
(b) Address Balto. MD.

19 (a) NOV 9 1948 (b) [illegible] Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1948, at M

21. I certify that death occurred on the date above stated, that I attended deceased from April 14 1948 to Nov 7 1948, and that I last saw h[illegible] alive on Nov 7 1948.

Immediate cause of death: Carcinoma of breast with Metastasis

Duration: 2yrs

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Ernest N. Kahn

Address 1730 Eye & Ear Hosp. Date signed 11/9/48
(M) (D)

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G68424

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 18-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1041 Sarah Ann Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NELLIE JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1901

8. AGE: Years 47 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace: Clayton, N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Demison Richardson
13. Birthplace: N. C.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: N

16 (a) Informant: David Jones (husband)
(b) Address: 1041 Sarah Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director: Mrs. Katie R. Williams
(b) Address: 322 N. Monroe St.

19 (a) NOV 9 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1948, at 10:05 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema

Due to Hypertensive cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner
Date signed 11-6-48

VS 191

668425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668425

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1826 E. Federal St.
(c) Hospital or institution: 8 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 E. Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John M. Cavanaugh

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 15th 1887

8. AGE: Years 61 | Months 2 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Retired

FATHER
12. Name Thomas Cavanaugh
13. Birthplace Cumberland Md.

MOTHER
14. Maiden Name Margaret Welsh
15. Birthplace Cumberland Md.

16 (a) Informant Mrs Mary A. Cavanaugh
(b) Address 1826 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St

NOV 9 1948 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8th 1948 at 10 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 11/8 1948
and that I last saw h alive on 19 .

Immediate cause of death Bronchopneumonia — Duration

Due to Arteriosclerotic C-V.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Christian F. Liebl

Address 11 W. Biddle St. Date signed 11/8/48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G68426

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1726 N.Wolfe Street
(c) Hospital or institution: 8.06
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 N.Wolfe Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Claude H.Atzrodt

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 214-01-9881

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Minnie Widerman
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Nov.3rd.,1876

8. AGE: Years	Months	Days	If less than one day
72	0	4	######## min.

9. Birthplace Hanover, Pennsylvania (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Ship Yard Clerk

FATHER
12. Name Harry Atzrodt
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna McFarland
15. Birthplace Virginia

16 (a) Informant Mrs.Minnie Atzrodt (Wife)
(b) Address 1726 N.Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory Mt.Olivet
Location Hanover, Pennsylvania

18 (a) Funeral director George J.Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) Nov 9 1948 (Registered by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7th., 1948 at 11.00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1948 to Nov. 7 1948. and that I last saw him alive on Nov 7 1948.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Conrad L. Richter M.D.
Address 1206 N. Wash St. Date signed 11/8/48

Conrad L. Richter

V S 150

B427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G68427

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 1517 N. Bond Street

(c) Hospital or institution: 8 06

(d) Length of stay in hospital or inst. (yrs., mos., or days): None

(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County: City

(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No.: 1517 N. Bond Street
(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country:

3 (a) FULL NAME: Mary Frances Moore (Mollie F. Moore)

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
None	None	Female	White	Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 18th., 1867

8. AGE: Years	Months	Days	If less than one day
81	8	20	########## min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business:

FATHER

12. Name: Daniel Moore

13. Birthplace: Ireland

MOTHER

14. Maiden Name: Julia Lacy

15. Birthplace: Ireland

16 (a) Informant: Mrss. Anna T. Moore (Sister)

(b) Address: 1517 N. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/10/48 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral

Location: Edmondson Avenue, Balto; Md.

18 (a) Funeral director: George J. Ruth, Inc.

(b) Address: 1735 Harford Avenue

19 (a) Nov 9 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7th 1948, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from November 1947 to Nov. 7 1948 and that I last saw h[illegible] alive on October 11 1948

Immediate cause of death	Duration
Myocardial degeneration of Heart	about 2 years
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: Kane Trounstine M.D.

Address: 623 E. N. Ave. Date signed: 11/8/48

V S 150

Please write plainly, with unfading ink. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G68428

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or Institution: St. Joseph's Hosp. 9 06

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.

(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore, 18 (If outside city or town limits, write RURAL and give town)

(d) Street No. 1710 Chilton St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mrs. Ella Agnes Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife William Marshall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/13/85

8. AGE: Years 63 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Dressmaker

11. Industry or business Title Company

FATHER

12. Name John Wicht

13. Birthplace St Louis, Mo

MOTHER

14. Maiden Name Mary E. Kerr

15. Birthplace Baltimore

16 (a) Informant William M. Murphy

(b) Address 1710 Chilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Road

18 (a) Funeral director Chas. F. Evans Son

(b) Address 118 W Mt Royal Ave

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1948 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1948 to Nov 7 1948 and that I last saw h[illegible] alive on Nov 7 1948

Immediate cause of death	Duration
Pulmonary Edema	
Due to Coronary Thrombosis	
Due to Arterio-sclerotic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature Roy E. Rusmisel Jr.

Address D. Joseph's Hospital Date signed 11/7/48

VS 150

8429

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 668429

477

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave
(c) Hospital or institution: Maryland General Hos
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 3 mos 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 2635 N. Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RETA GRAHAM

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John A Graham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR 17 1868

8. AGE: Years 6. | Months 7 | Days 3 21 | If less than one day: hr. min.

9. Birthplace Queen Annes Co. Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name James E. Reynolds
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Rhodes
15. Birthplace Maryland

16 (a) Informant John A. Graham SR
(b) Address 2635 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W Pleasant St Baltimore, Md

19 (a) NOV 9 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 07 NOV 1948 at 3:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 17 OCT 1948 to 7 NOV 1948 and that I last saw HER alive on 7 NOV 1948.

Immediate cause of death: CARDIORESPIRATORY FAILURE — Duration: 2 HOURS

Due to: CARCINOMA - RIGHT LUNG & METASTASIS — 1 YR??

Due to: LEFT LUNG, PLEURA, PERICARDIUM, MYOCARDIUM, & SPLEEN.

Other Conditions: BILATERAL PLEURAL EFFUSION (Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy: SEE ABOVE

PHYSICIAN: Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald L. England M. D.
Address Maryland Gen Hosp Date signed 7 Nov 48

VS 190

68430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117B

Registered No. 68430

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 33 Dolcbert
(b) Street address ~~2606 Maryland~~
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Maryland (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME MR. DANIEL KILLEN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-16-5600

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	MARRIED

6 (b) Name of husband or wife Mrs. Delia Killen
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) May 1, 1882

8. AGE: Years	Months	Days	If less than one day
66	6	6	— hr. — min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Thomas Killen
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine Daily
15. Birthplace Maryland

16 (a) Informant Wife
(b) Address 2606 Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director Chas. F. Ennis Son
(b) Address 118 W Mt. Royal Ave

19 (a) NOV 9 - 1948 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1948, at 2 23 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1948, to Nov. 7 1948, and that I last saw him alive on Nov. 7 1948.

Immediate cause of death	Duration
Cardiac + Resp. failure	
Due to Perforated Duodenal Ulcer with hemorrhage	
Coronary Thrombosis with infarction of Myocardium	
Other Conditions Arteriosclerotic Cardiovascular Disease	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Hopkins III
Address Union Memorial Hosp Date signed 11/7/48 M. D.

VS 190

668431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 668431 Registered No. 12/a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1035 Tiffany Court
(c) Hospital or institution: 11-04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 Tiffany Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: EDWARD WALKER

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 217-05-5368

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leola

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 2/8/1886

8. AGE: Years 62 | Months 8 | Days 29 | If less than one day: hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Benj. Walker
13. Birthplace N.C.

MOTHER
14. Maiden Name Lucy Alston
15. Birthplace N.C.

16 (a) Informant Leola Walker (Wife)
(b) Address 1035 Tiffany Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Ann Arundel County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) NOV 9 - 1948 (b) Name rec'd by registrar Funeral for Williams M.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7th 1948, at 6:10 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10/10/48 to 11/7/48 and that I last saw him alive on 10/7/48.

Immediate cause of death: Cardiac Renal. Duration: 1 Month
Due to: Interstitial Nephritis Chron.
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. T. Gibson M.D.
Address 522 N. Arlington Ave

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 159

668432

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

668432

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. & Cl
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Eutaw Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME William Mahrer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Catherine Mahrer
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Oct 24 1892

8. AGE: Years	Months	Days	If less than one day
56	-	16 17	..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Secretary to
11. Industry or business Congressman

FATHER
12. Name Joseph Mahrer
13. Birthplace unknown Balto.

MOTHER
14. Maiden Name Mary Walker
15. Birthplace unknown Balto.

16 (a) Informant Hosp. records
(b) Address .....

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 10 48 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER - CEM
Location 4300 BELAIR RD

18 (a) Funeral director DIPPEL BROS
(b) Address 1800 E LOMBARD ST

19 (a) NOV 9 1948 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1948, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 19 48 to Nov. 7 19 48 and that I last saw h[illegible] alive on Nov. 7 19 48

Immediate cause of death Acute coronary thrombosis — Duration .....
Due to .....
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury .....
23. Signature T. Dwinski
Address Mercy Hosp. Date signed 11/7/48 M.D.

VS 130

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G68433

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Bank Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THOMAS BRONIKOWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-1096

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Married

6 (b) Name of husband or wife Irmalee
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1899

8. AGE: Years	Months	Days	If less than one day
49	1	5	hr. min.

9. Birthplace Sayersville, N.J. (Town, county, and state)
10. Usual Occupation Freight Handler
11. Industry or business Transportation

FATHER
12. Name Joseph Bonikowski
13. Birthplace Poland

MOTHER
14. Maiden Name Catherine Wojciechowski
15. Birthplace Poland

16 (a) Informant Mrs. Irmalee Bronikowski
(b) Address 1721 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Taylor Avenue

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1505 Eastern Avenue

19 (a) NOV 9 - 1948 (rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1948, 9:25 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Bruyn M.D. (Medical Examiner)
Date signed November 8, 1948

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668434 4E 128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668434

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town Taboro (If outside city or town limits, write RURAL and give town)
(d) Street No. ? (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ronald M. Hatch
3 (b) If veteran, name war
3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9 1948 at 3:45-a M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-25-1948 to 11-9 1948, and that I last saw h[illegible]m alive on 11-9 1948.

	Duration
Immediate cause of death: Cystic fibrosis of the pancreas, chronic with pulmonary fibrosis	
Due to:	
Due to:	
Other Conditions: (Include pregnancy within 3 months of death)	
Date of operation:	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

4. Sex	Male
5. Color or race	White
6 (a) Single, married, widowed, or divorced.	
6 (b) Name of husband or wife	
6 (c) If alive, give age	years
7. Birth date of deceased (mo., day, yr.)	3-5-48
8. AGE: Years / Months / Days	8 / 4 /
If less than one day: hr. / min.	
9. Birthplace (Town, county, and state)	N. C.
10. Usual Occupation	
11. Industry or business	
FATHER 12. Name	George Frederick Hatch
FATHER 13. Birthplace	Canada
MOTHER 14. Maiden Name	Allene R. Lowry
MOTHER 15. Birthplace	N. C.
16 (a) Informant	
(b) Address	JOHNS HOPKINS HOSPITAL
17 (a) (Burial, cremation, or removal)	Removal
17 (b) Date thereof (month) (day) (year)	Nov 9/48
17 (c) Cemetery or crematory	Taboro Memorial Park
Location	Taboro N C
18 (a) Funeral director	Lillard Funeral Home
18 (b) Address	200 E College Washington N C
19 (a) (Date received by registrar)	NOV 9 - 1948
Registrar	

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Ryan M. D.
Address Johns Hopkins Hosp Date signed 11-9-48

VS 150

668435

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 170c

668435 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 11-04
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 2½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits write RURAL and give town)
(d) Street No. 1223 McCulloh Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD RIVERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1890

8. AGE: Years 58 | Months 8 | Days 16 | If less than one day hr. min

9. Birthplace Florence, S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Andrew Rivers
13. Birthplace Florence, S. C.

MOTHER
14. Maiden Name Victoria ?
15. Birthplace Florence, S. C.

16 (a) Informant Lillian W. Kier
(b) Address 1036 W. Fayette St., Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Charles H. Alexander
(b) Address 1209 McCulloh St, Balt, Md.

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6, 1948 at 2:40 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Concussion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 6, 1948 at 12 P. M.
(b) Where did injury occur? 1223 McCullough St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fractured struck by taxicab

23. Signature Earl L. Royster M.D. Medical Examiner.
Date signed Nov. 7, 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. 68436

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) ....
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 480 N Wright Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country ....

3 (a) FULL NAME Patrick Harris

3 (b) If veteran, name war None | 3 (c) Social Security Account No. No

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife ....
6 (c) If alive, give age ....

7. Birth date of deceased (mo., day, yr) April 22, 1932

8. AGE: Years 16 | Months 6 | Days 17 | If less than one day ....hr. ....min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation news Salesman

11. Industry or business

FATHER 12. Name William H Harris
FATHER 13. Birthplace North Carolina

MOTHER 14. Maiden Name Lilla Lee Willard
MOTHER 15. Birthplace North Carolina

16 (a) Informant ....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12, 1948 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location ....

18 (a) Funeral director A Raymond Evans
(b) Address 1500 W Baltimore St

19 (a) NOV 9 - 1948 (Date rec'd by registrar) (b) Huntington for Baltimore, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1948 at .... M

21. I certify that death occurred on the date above stated; that I attended deceased from .... 19.... to .... 19.... , and that I last saw h.... alive on .... 19....

Immediate cause of death Acute pul. edema & consolidation RUL — Duration ....

Due to ? Pul. infection, ? Pneumonia

Due to ....

Other Conditions RHD & Mitral stenosis & insufficiency (Include pregnancy within 3 months of death)

Date of operation ....

Major findings of operation: ....

Results of autopsy: RHD & Mitral & Tricuspid

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ....
(b) Date of occurrence .... at .... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? .... While at work? .... (Specify type of place)
(e) Means of injury ....

23. Signature [signature] M.D.
Address The Johns Hopkins Hosp Date signed 11/9/48

VS 180

G68437
Dr. Golley

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G68437
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2600 Ailsa Avenue
(c) Hospital or institution: 2203
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 Ailsa Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA ACHTERKIRCHEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 7, 1874

8. AGE: Years	Months	Days	If less than one day
74	10	2	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Hohmann
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Schroeder
15. Birthplace Germany

16 (a) Informant Mr. Wm. Achterkirchen
(b) Address 2600 Ailsa Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-48 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Washington, D.C.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) NOV 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9-48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1948 to 11/9 1948
and that I last saw h[illegible] alive on 11/9 1948

Immediate cause of death Uremia
Hypertension (Nephritis)

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify) (Place)
(e) Means of injury.

23. Signature [illegible] M.D.
Address 5702 Harford Rd Date signed 11/9/48

X

VS 189

668438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

668438 Registered No.

GM 102317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 Washington ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Hankey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband ~~or wife~~ Eugene Hankey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1869

8. AGE: Years	Months	Days	If less than one day
79	5	24	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Conner
13. Birthplace MD.

MOTHER
14. Maiden Name Lydia Harrison
15. Birthplace MD.

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) NOV 9 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11- 8- 1948 12.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6- 24- 1946 to 11-8- 1948, and that I last saw BR alive on 11- 8 - 1948

Immediate cause of death: Cardiac Failure — Duration: 2 mos?

Due to: arteriosclerotic Heart Disease — 4 yrs?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: NONE

of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas P. Jernigan M. D.
Address BALTIMORE CITY HOSP Date signed 11-8-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

68439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G68439 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 E. Biddle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 E. Biddle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry W. Walker

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-1506

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Margarett E. Walker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 16, 1876

8. AGE: Years	Months	Days	If less than one day
72	9	22	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Sec. Manager
11. Industry or business Ind. Retail Grocer's Assoc

FATHER
12. Name George W. Walker
13. Birthplace Maryland

MOTHER
14. Maiden Name Ella P. Anthony
15. Birthplace Maryland

16 (a) Informant Mrs. Margarett E. Walker
(b) Address 2601 E. Biddle Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/12/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Memorial
Location Washington Boulevard

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street.

19 NOV 10 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8, 1948, at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 8 1946, to 11 8 1948, and that I last saw h[illegible] alive on 11 8 1948.

Immediate cause of death	Duration
Coronary Thrombosis	1½ hrs
Due to Arterial Arteriosclerosis	Hyp
Due to	
Other Conditions Mitral Regurgitation	6 yrs

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Miller M.D.
Address 1500 N Bdwy Date signed 11/9/48

97

VS 150

G68440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68440

GM. 96573

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Hollins ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Wid.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March. 14-1879

8. AGE: Years 69 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Lituania
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Vincent. Miller
13. Birthplace Lithuania

MOTHER
14. Maiden Name Annie ?
15. Birthplace Lituania

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 10-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Joseph Kassuphen Sons
(b) Address 602 S. Paca St.

19 NOV 10 1948 (Date rec'd by Registrar) (b) Turnington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11- 6 - 1948 at 11.45 MP

21. I certify that death occurred on the date above stated; that I attended deceased from 10- 9- 1945 to 11- 6- 1948.
and that I last saw h in live on 11- 6- 1948.

Immediate cause of death
CARDIAC FAILURE — Duration 6 MOS

Due to
SYPHILITIC HEART DISEASE — 3 YEARS

Due to 2 AORTIC INSUFFICIENCY

Other Conditions TABES DORSALIS — 3 YEARS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas P. Jennings M. D.
Address BALTIMORE CITY HOSP. Date signed 11-7-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

68441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 569

G68441
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town Miami Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 Marseilles Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Ray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 | Months | Days | If less than one day, hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Mayer
13. Birthplace Russia

MOTHER
14. Maiden Name Fay
15. Birthplace Russia

16 (a) Informant Ray Gordon
(b) Address 1720 Marseilles Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory
Location Chicago Ill

18 (a) Funeral director Jack Lewyne
(b) Address 2160 Estaire Place

19 NOV 10 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1948, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29-1948 to 11-9-1948, and that I last saw him alive on 11-9-1948.

Immediate cause of death
Post-operative (craniotomy) shock

Due to Meningioma

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irvin M. Cushner M. D.
Address Sinai Hospital, Md. Date signed 11-10-48

68442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

Registered No. 68442

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Do A
(e) Length of stay in Baltimore (yrs., mos., or days) 50yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Brookfield Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY SNYDERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mollie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 61 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Poland

MOTHER
14. Maiden Name Rebecca
15. Birthplace Poland

16 (a) Informant: Sylvan Snyderman
(b) Address 3661 Wabash Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-48 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 NOV 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1948 at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Illuminating Gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 9/48 at approx. 9 A.M.
(b) Where did injury occur? 2212 Brookfield Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Mouth to gas outlet

23. Signature Earl K. Long M.D. Medical Examiner.
Date signed 11/9/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

68443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

113

✓ 68443 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2408 Spring Hill Ave #15
(c) Hospital or institution: Sinai Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Springhill Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Gimenick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day: hr.	min.
55				

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Russia

MOTHER
14. Maiden Name Kuda
15. Birthplace Russia.

16 (a) Informant Rose Gimenick
(b) Address 2408 Springhill Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-10-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis, Inc
(b) Address 2100 Eutaw Place
(b) Huntington Williams M.D. Registrar

NOV 10 1948 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1948, at 6 45 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 15 1948 to Nov 9 1948, and that I last saw h alive on Nov 9 1948.

Immediate cause of death: Bullous emphysema — Duration

Due to

Due to

Other Conditions not determined (include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: to be done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl Hunter M. D.
Address Sinai Hospital Date signed Nov. 9 1948

Chas. Silverstein X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G68434

CERTIFICATE OF DEATH

To be approved by medical examiner 1866

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 S. Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Louisa Brendel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 22, 1863

8. AGE: Years	Months	Days	If less than one day
85	8	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Charles Michelman
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Weidmeier
15. Birthplace Germany

16 (a) Informant Anna Brendel
(b) Address 1012 S. Ellwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem. Pk.
Location Washington Blvd.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 NOV 10 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1948, at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 8 1948, and that I last saw h[illegible] alive on Nov 8 1948.

Immediate cause of death: Hypostatic pneumonia — Duration 2 d.
Antecedent cause
CERTIFICATION APPROVED BY
Due to [signature] M.D.
CHIEF OR ASST. MEDICAL EXAMINER
Duration Fracture surgical neck [illegible] humerus Rt. 32 yrs.
Other Conditions Diabetes mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 1/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Nov. 1, 1948 at ? A.M
(c) Where did injury occur? 1012 S. Ellwood Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fall down steps, inside

23. Signature [signature] M.D.
Address [illegible] Date signed 11/8/48

VS 150

68445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G68445 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123 N. Carey st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa A. Mackey

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Robert J.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 1st 1876
8. AGE: Years 72 | Months 7 | Days 8 | If less than one day: hr. mjn.
9. Birthplace Richmond Va. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name J. Thomas Duffy
13. Birthplace Philadelphia Pa.

MOTHER
14. Maiden Name Mary E. O'Connor
15. Birthplace Ireland

16 (a) Informant Mrs Nellie T. Roche
(b) Address 123 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Richmond Va

18 (a) Funeral director John J. Coyne & Son
(b) Address 901-03 Hollins St

19 (a) NOV 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9th 1948 at 2 45 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 27th 1948 to Nov. 9- 1948 and that I last saw h alive on Nov. 9- 1948

	Duration
Immediate cause of death Cerebral apoplexy	12 hrs.
Due to arteriosclerosis	3 yrs
Due to Chronic nephritis	3 yrs
Other Conditions Arthritis.	5 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. J. McDermott M. D.
Address 1136 Eutaw Place Date signed 11/10/48

VS 150

X

68446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

G68446
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 N. Freemount St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. Freemount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISABELLE HALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Owen R. Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1868

8. AGE: Years 80 | Months 7 | Days 15 | If less than one day: hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isaac Smith
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Mary Willows
15. Birthplace Frederick, Md.

16 (a) Informant Eloise Turner
(b) Address 79 St. Nicholas Place

17 (a) Burial (b) Date thereof Nov. 11, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rebecca Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George W. Holland
(b) Address 1601 Druid Hill Ave.

19 (NOV 10 1948) Washington Williams, M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 19 48 at 1:45 A. M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place or public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 11/6/48

VS 151

Numbers must be written in words, e.g., one not 1; and all dates must be complete. Physicians: please write the causes of death clearly and legibly.

G68447

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68447
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Woodington Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB SCHIECK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 26, 1873

8. AGE: Years	Months	Days	If less than one day
74	11	14	hr. min.

9. Birthplace
(Town, county, and state)
10. Usual Occupation Retired bartender
11. Industry or business Miller Bros. Restaurant

FATHER
12. Name John Jacob Schieck
13. Birthplace Germany

MOTHER
14. Maiden Name Alize Kron
15. Birthplace Germany

16 (a) Informant Franklin Square Hospital Records
(b) Address Baltimore, Maryland

17 (a) Burial (b) Date thereof Nov 12-48
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Washington Blvd

18 (a) Funeral director Chas. H. Blake
(b) Address 1 Washington Blvd

NOV 10 1948 (b) for Williams, M.D.
(Date received by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1948 12:08 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive cardiovascular disease.
History of chronic alcoholism.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George T. Merrill M.D.
Medical Examiner.
Date signed 11-10-48

PRINT NAME, WITH ENDING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G68448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G68448 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Elliott Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Margaret Theresa McAvoy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Fe. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 1, 1865

8. AGE: Years 83 | Months 6 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Thomas McAvoy
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Dunne
15. Birthplace Ireland

15 (c) Informant Mary E McAvoy
(b) Address 3006 Elliott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-48 (Month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 2060 E Balt. St.

NOV 10 1948 (Registered by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1948, at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/ 1948 to 11/8/ 1948, and that I last saw her alive on 11/8/ 1948.

Immediate cause of death: Cardio-respiratory failure — Duration

Due to Cardiac pulmonary congestion

Due to Arteriosclerosis

Other Conditions - Staphylococcus aureus Bottle

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature [illegible] Hospital
Address [illegible] Date signed 11/8/48

G68449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G68449
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 Cator Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Cator Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia Duke Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband ~~or wife~~ Frank H. Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-14-1855

8. AGE: Years	Months	Days	If less than one day
93 94	8	24	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Augustan H. Duke
13. Birthplace Maryland

MOTHER
14. Maiden Name Josephine Rosenstiel
15. Birthplace Maryland

16 (a) Informant Mrs. Cath. T. Donnelly
(b) Address 618 Cator Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-48 (month) (day) (year)
(c) Cemetery or crematory St. Mary Govans
Location Homeland Ave

18 (a) Funeral director John L. Moran
(b) Address 3000 E. Baltimore St.

19 (a) (Date rec'd by Registrar) Registrar

NOV 10 1948
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1948 at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1946 to Nov 8 1948 and that I last saw h alive on Nov 8 1948.

Immediate cause of death Chron Myocarditis — Duration 3 yrs

Due to

Due to

Other Conditions Acute Cardiac Dilatation — 1948

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. W. Bishop M. D.
Address 503 Sheridan Ave Date signed Nov 9-48

X

DEATHS WITHIN TWENTY-FOUR HOURS AFTER ENTERING HOSPITAL MUST BE REPORTED IMMEDIATELY BY TELEPHONE. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G68450
LCH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12 B

Registered No. G68450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3485 Fairsun Court
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Helen Bush

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Seperated

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/1904

8. AGE: Years	Months	Days	If less than one day
44	8	24 23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Frank Stock
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Miller
15. Birthplace Maryland

16 (a) Informant Balto. City Hosp. Records
(b) Address 4940 Eastern Aveme

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Park & B. M. Walter
(b) Address Huntington Williams, Mgr

19 (a) [illegible] (Date received by registrar) (b) Registrar

NOV 10 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9/48 19 , at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/48 19 to 11/9/48 19 , and that I last saw her alive on 11/9/48 19 .

Immediate cause of death	Duration
Coronary thrombosis	4 hr.
Due to ?	
Due to Far advanced Pulmonary Tuberculosis	6 yr.
Due to	6 yr.
Other Conditions Diabetes M.	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Frank M. Shipley M. D.
Address Balto. City Hosp. Date signed 11-7-48

G68451

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G68451
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Street
(c) Hospital or institution: Union Memorial Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 W. 40th St. Balto 11 md.
(If rural give location)
(e) Citizen of foreign country? W No (Yes or No)
If yes, name country

3 (a) FULL NAME G. Ridgely Sappington (G. RIDGELY SAPPINGTON)
3 (b) If veteran, name war
3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1948, at 9 40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Anne Richter Sappington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1883

8. AGE: Years	Months	Days	If less than one day
65	10	5	hrs. min.

9. Birthplace Frederick Md.
(Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business Law

FATHER
12. Name Francis R Sappington
13. Birthplace Maryland

MOTHER
14. Maiden Name Marie John
15. Birthplace Maryland

16 (a) Informant Hospital record and Mrs Sappington
(b) Address 606-W-40-St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (H. F. MOWEN SUC.) 100 N. NORTH AVENUE

NOV 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

Immediate cause of death Acute Congestive Heart Failure — Duration 3 days

Due to Damaged myocardium from old coronary - c — 6 yrs.

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Smith, Jr. M. D.
Address Union Memorial Hosp Date signed 11/9/48

VS 150

G68452

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G68452
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert and Santoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 St Paul St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET B. McBRIARTY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John Mc Briarty
6 (c) If alive, give age dec years

7. Birth date of deceased (mo., day, yr.) 3-7-1865

8. AGE: Years	Months	Days	If less than one day
83	8	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Alphonse Beil
13. Birthplace Bavaria

MOTHER
14. Maiden Name Not obtainable ?
15. Birthplace Bavaria

16 (a) Informant Miss Barbara Mc Briarty (daughter)
(b) Address Same

17 (a) Burial (b) Date thereof 11/12/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director H. W. Meade and Son
(b) Address 803 W. Calvert St.

NOV 10 1948
(Date rec'd by registrar)

(Functioning for) Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 9 - 1948, at 11 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 - 4 - 1948 to 11 - 9 - 1948, and that I last saw her alive on 11 - 9 - 1948.

Immediate cause of death	Duration
Cardiac failure.	
Congestive.	
Due to Bronchopneumonia	6 days
Due to	
Other Conditions Emphysema arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allyn F. Judd M. D.
Address Mercy Hospital Date signed 11-9

VS 150

DO NOT WRITE IN THIS SPACE. Entries must be made in permanent black ink or typewriter. Please report separately on line 22. Please write plainly, with unfading ink. Physicians: please write the causes of death clearly and legibly. Please see that your answers are full, complete, and correct. Do not use abbreviations or ditto marks. If there is no entry for a space, write none, or 0 (zero). Please see that your answers are full, complete, and correct. Do not use abbreviations or ditto marks. If there is no entry for a space, write none, or 0 (zero). Please see that your answers are full, complete, and correct. Do not use abbreviations or ditto marks. If there is no entry for a space, write none, or 0 (zero). Please see that your answers are full, complete, and correct. Do not use abbreviations or ditto marks. If there is no entry for a space, write none, or 0 (zero). Please see that your answers are full, complete, and correct age is especially important.

G68453

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G68453
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 646 W. Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Susan Parker.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June [redacted] 1880

8. AGE: Years	Months	Days	If less than one day
68	5	6	hr. min.

9. Birthplace Davis Wharf Accomac Co. Va. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Parker.
13. Birthplace Accomac Co. Va.

MOTHER
14. Maiden Name Janie West.
15. Birthplace Accomac Co. Va.

16 (a) Informant Eula Davenport.
(b) Address 1128 Warner St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (b)
(Date received by registrar) Registrar

NOV 10 19[illegible]

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1948 at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1948 to Nov 7 1948. and that I last saw her alive on Nov 5 1948.

Immediate cause of death Respiratory failure

Due to Arteriosclerotic Cardiovascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Shorofsky M.D.
Address 601 N. Monroe St. Date signed 11/9/48 M/D

G68454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G68454

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. See correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St. 19-2
(c) Hospital or institution: Aged Women's & Aged Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) Entered Home Sept 22 1947
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 West Lexington St (If rural give location) Bal.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew B. Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 11 1867

8. AGE: Years 81 | Months 2 | Days 30 | If less than one day ____ hr. ____ min.

9. Birthplace Harford Co Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Josephus B. Reed

13. Birthplace Harford Co Md

MOTHER 14. Maiden Name Rosenath Ann Dowbow

15. Birthplace Harford Co Md

16 (a) Informant P. D. Reed Supt.

(b) Address 1400 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Bethel

Location Baltimore

18 (a) Funeral director Masters & Kent

(b) Address Parkersville Md

NOV 10 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1948, at 2 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1947 to November 1948, and that I last saw h.i.m alive on Nov. 10 1948

Immediate cause of death Cardiac Failure — Duration

Due to Coronary Thrombosis

Due to

Other Conditions Arteriosclerotic gangrene of extremities (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maryland Edward Day M.D.
Address 4-E-33rd St - 18 Date signed Nov. 10, 48

V S 150

G68455

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68455 ✓ 927 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave.
(c) Hospital or institution:
15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Belle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Belle Slossberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1887

8. AGE: Years	Months	Days	If less than one day
61	6	25	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Samuel Levy
13. Birthplace Russia

MOTHER
14. Maiden Name Leah
15. Birthplace Russia

16 (a) Informant Louis Slossberg
(b) Address 3804 Belle Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11/48 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Avenue

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North Avenue

19 (a) (Date rec'd by Registrar) NOV 11 1948 (b) Huntington for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1948 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1948 to Nov 10 1948 and that I last saw h w alive on Nov 10 1948

Immediate cause of death: Acute Cerebral Hemorrhage — Duration
Due to Ch Hypertention
Due to Ch myocarditis
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature A. L. Hometene
Address 704 E. Biddle St. Date signed 11/11/48 M.D.

X

G68456
LCH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 930 N. Broadway
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sally Shirey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/24/1877

8. AGE: Years	Months	Days	If less than one day
71	2	17	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jessie Jones
13. Birthplace Virginia

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Virginia

16 (a) Informant Balto. City Hosp. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St
11 1948 Baltimore (Maryland)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/48 19 , at 9:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29/48 19 , to 11/10/48 , and that I last saw h er alive on 11/10/48 19

Immediate cause of death pneumonia abscess — Duration 2 weeks

Due to

Due to

Other Conditions Diabetes Mellitus — 20 yrs
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Reichold M. D.
Address Balto City Hosp. Date signed 11-10-48

VS 150

1332

668457

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 668457

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians—please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 Greenmount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Greenmount (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA B. PEILAND

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Robert E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1879

8. AGE: Years	Months	Days	If less than one day
69	1	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Theodore Ruark
13. Birthplace Md.

MOTHER
14. Maiden Name Susan Guthrie
15. Birthplace Md

16 (a) Informant Mrs J. Cowan
(b) Address 1311 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.A. County, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) (b)
(Date rec'd by registrar) (Registrar)
NOV 1 1 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1948 at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1941 to Nov 9 1948 and that I last saw her alive on Nov. 9 1948-2 P.M.

Immediate cause of death — Duration
Acute Cardiac Failure
Due to Arteriosclerotic cardio-vascular disease.
Due to
Other Conditions Bronchiectasis.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature L. B. Stevens Coroner
Address 3400 Date signed 11/10/48

G68458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

G68458 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made in this record and signature written in full when certificate is completed. Do not abbreviate. Give exact residence of deceased. If in a city, give street address or location. If outside city limits, write RURAL and give town. If rural, give location. If in hospital or institution, give its name instead of street address. If death occurred in a hospital or institution, the person in charge of the institution must fill in items 1 to 9 inclusive. If the deceased was a transient or stranger, or if death occurred on the street, the coroner must fill in items 1 to 9 inclusive. If death occurred elsewhere than in a hospital or institution, the informant must fill in items 1 to 9 inclusive. Physicians: please write the causes of death clearly and legibly. Be sure to answer all questions, and to fill in every space with the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 435 N. East Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-10

(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 N. East Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Victoria Frances Maccis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ Martin Maccis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/23/1884

8. AGE: Years	Months	Days	If less than one day
63	10	17	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Skodmin
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Victoria McClelland-dght
(b) Address 435 N. East Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/48 (month) (day) (year)
(c) Cemetery or ~~xxxxxx~~ Holy Redeemer
Location 4430 Belair Rd. Balto. Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison St.

NOV 11 1948 (b) Washington Williams, M.D. Coroner

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9 1948 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1948 to 11/9 1948 and that I last saw her alive on 11/5 1948

Immediate cause of death Cardiac Hemorrhage of Brain — Duration 48 Hrs

Due to

Due to

Other Conditions High Blood Pressure Hardening of Arteries

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide /
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify)
(e) Means of injury X

23. Signature D A.C. Heaver M.D.
Address 3701 Fairmount Blvd
11/9/48

VS 159

668459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

668459 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 127 N. Duncan Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 127 N. Duncan Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Prokop Pernica

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of ~~husband~~ or wife Veronica (nee Shimek)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1866

8. AGE: Years	Months	Days	If less than one day: hr.	min.
82	4	4		

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Veronica Shimek Pernica
(b) Address 127 N. Duncan Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/48 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison Street

19 NOV 11 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8 1948, at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1946 to Nov 8 1948.
and that I last saw h[illegible] alive on Nov 8 1948

Immediate cause of death: Myocardial degeneration — Arteriosclerosis — Senility — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis F. Kleiner, M.D.
Address 762 E. Monument Date signed 11/9/48

PLEASE WRITE PLAINLY, with unfading ink. Every item of information should be entered. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

68460 ✓ 68460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1132. Pennsylvania Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 - PENNA. AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Eva mae Reese
(b) If veteran, name war
(c) Social Security Account No. 212-05-8469

4. Sex: M | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 10, 1896

8. AGE: Years 52 | Months 5 | Days - | If less than one day hr. min.

9. Birthplace KENT CO. MD. (Town, county and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant THOMAS TAYLOR
(b) Address 1132 - PENNA AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-13-48 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Oakland

18 (a) Funeral director A. H. Hull
(b) Address

19 (a) NOV 11 1948 (Date rec'd by registrar) Arthington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1948, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1948, to 1948, and that I last saw him alive on Nov. 9 1948

Immediate cause of death Hypostatic pneumonia — Duration 3 days.

Due to Arteriosclerotic cardiovascular disease.

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bruce V. Benjamin
Address 1837 Edmondson Ave. Date signed 11/9/48 M.D.

VS 159

668461 668461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 9-D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2577 W. BALTIMORE ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2577 N BALTIMORE ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George BEAL

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-03-2169

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day hr.	min.
77				

9. Birthplace Leith (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER 12. Name ? Beal
13. Birthplace Leith

MOTHER 14. Maiden Name ?
15. Birthplace Leith

16 (a) Informant Anna Beal
(b) Address 2577 W Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 11 -48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd
18 (a) Funeral director Joseph Lazarakos Jr
(b) Address 602 E Washington Blvd

NOV 11 1948 (b) Huntington Hollins Registrar
(Date rec'd by registrar)

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1948, at 7.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 25 1947 to November 8 1948, and that I last saw him alive on November 7 1948.

Immediate cause of death CARDIAC FAILURE — Duration 4 YEARS

Due to CHRONIC MYOCARDITIS AND MYOCARDIAL DEGENERATION — 8-10 YRS

Due to ARTERIOSCLEROSIS, generalized — MANY YEARS

Other Conditions HYPERTROPHY OF THE PROSTATE GLAND
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin M Borden M. D.
Address 203 W. Fayette St Date signed 11/9/48

G68462

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

Registered No. G68462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Patapsco Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY M WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-1629

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1877

8. AGE: Years 71 | Months 4 | Days 17 | If less than one day hr min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Car Shop Hand

FATHER
12. Name ? Wilson
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Annie M. Torchia (niece)
(b) Address 3447 Woodstock Avenue (Tu. 6628)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 13 1948 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location A. A. Co, Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles St. Balto. 30, Md.

19 (a) [illegible] 1948 (b) [illegible] Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1948, at 7.30PM

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury At M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Ryon M.D.
Medical Examiner.
Date signed November 10, 1948

X

668463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

668463 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 W. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE FLORENCE CARRICK

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John W. Carrick, Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1876

8. AGE: Years 72 | Months 5 | Days 21 22 | If less than one day hr. min.

9. Birthplace: Baltimore County
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: George W. Mellon
13. Birthplace: Baltimore County

MOTHER
14. Maiden Name: Beilemia Ritter
15. Birthplace: Baltimore County

16 (a) Informant: Mrs. Mary M. Davis
(b) Address: 1905 W. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olive
Location: Randallstown Md.

18 (a) Funeral director: WILLIAM J. TICKNER & SONS
(b) Address: Baltimore, Maryland

NOV 11 1948 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1948, at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Subdural Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 15-2
(a) Date of injury 11-8-48 at ? A. M.
(b) Where did injury occur? 1905 W. North Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury: Fell down steps inside

23. Signature George W. Mellon M.D.
Medical Examiner.
Date signed 11-12-48

VS 151

668464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

668464 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4203 Springdale Ave.

(c) Hospital or institution: Virginia Lee Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4300 Springdale Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME MARGUERITE CONRAD CARR

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife B. Ashby Carr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 13, 1871

8. AGE: Years	Months	Days	If less than one day
77	9	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Madison Monroe Conrad

13. Birthplace Virginia

MOTHER 14. Maiden Name Mary Simms

15. Birthplace Md.

16 (a) Informant Miss Gladys Carr

(b) Address 4300 Springdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/48 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) NOV 10 1948 (Date rec'd by registrar) (b) Huntington Williamsport Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1948 at 9:05p M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to 9 Nov. 1948 and that I last saw her alive on 5 Nov. 1948

Immediate cause of death: Broncho pneumonia — Duration: 4 days

Due to: Cerebral hemorrhage — 2 yrs.

Due to: General & cerebral arteriosclerosis — 10 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Louis E. Wice

Address 920 St. Paul St. Date signed 10 Nov. '48

668465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G68465 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Raynes Ave. Dukeland St.
(b) Street address West Baltimore General Hosp
(c) Hospital or institution: 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 195 Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Sicki) Samuel Balser

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-8726

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23, 1899

8. AGE: Years	Months	Days	If less than one day
48	11	17	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Self employed

11. Industry or business

FATHER
12. Name Raphael Balser
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Brenner
15. Birthplace Russia

16 (a) Informant Maurice Balser
(b) Address 3511 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12, 1948 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) 11/14/48 (Date rec'd by Registrar) Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/48 19 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 19 48 to 11/10 19 48.
and that I last saw him alive on 11/10 19 48.

Immediate cause of death Myocardial infarction — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Luther M.D.
Address NW Balt Gen Date signed Nov 12

Coop X

G68466

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

87c

G68466 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 S Patterson Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 S Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry O. Elwist

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed~~, or ~~divorced~~.
Male	White	Married

6 (b) Name of husband or wife Catherine Elwist
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13 1878

8. AGE: Years	Months	Days	If less than one day
70	-	27	hr. min.

9. Birthplace Iowa (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John G Elwist
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret L. Giacomte
15. Birthplace Germany

16 (a) Informant Catherine Elwist
(b) Address 215 S Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12 1948 (month) (day) (year)
(c) Cemetery or crematory Ebenezer Lutheran
Location Philadelphia Road.

18 (a) Funeral director John G Rosan
(b) Address 3000 Baltimore St

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Clinton Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1945 to Nov. 9 1948.
and that I last saw him alive on Nov. 9 1948.

Immediate cause of death Paralysis Agitans — Duration 10 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Linden M. D.
Address 14 S. Broadway Date signed 11/10/48

VS 150

X

668467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 668467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Also correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 339 Glynn Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR SCOTT HAINES

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	212-01-4202

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed or divorced~~
Male	White	M

6 (b) Name of husband or wife Fannie E. Haines
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 20, 1867

8. AGE: Years	Months	Days	If less than one day
81	7	22	hr. min.

9 Birthplace Uniontown, Maryland (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Canton Bank

FATHER
12. Name John R. Haines
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Blackston
15. Birthplace Maryland

16 (a) Informant Kenneth B. Haines
(b) Address 2926 Riggs Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive
Location Randallstown, Md.

18 (a) Funeral director Little's Funeral Home
(b) Address 2700 Edmondson Avenue

19 (a) NOV 11 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1948, at 5:20 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
A.S.C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle L. Royer M.D.
Medical Examiner.
Date signed 11 Nov 48

VS 151

G68468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G68468

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME PETER CROCKETT SMITH

3 (b) If veteran, name war ?
3 (c) Social Security Account No. 579-14-5149

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Burke Smith
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) FEB. 8, 1895

8. AGE: Years 53 | Months 10 | Days 2 | If less than one day ##### min.

9. Birthplace Tylerton, Md. (Town, county, and state)
10. Usual Occupation Master, Tug Boat
11. Industry or business Harbor Towing Company

FATHER
12. Name Frank Smith
13. Birthplace Tylerton, Md.

MOTHER
14. Maiden Name Virginia Marshall
15. Birthplace Tylerton, Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Avenue, Balto. Co. Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) Date 1948 (b) [illegible] registrar

NOV 11 1948

V S 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 10 1948, at 12:37 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1948 to Nov. 10 1948, and that I last saw him alive on Nov. 10 1948.

Immediate cause of death Coronary thrombosis — Duration 1 hr

Due to generalized arterio-sclerotic disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address Clinical Director Date signed 11/10/48

6d8169

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

181

Registered No. 6d8169

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 Mosher Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: ELLA ALLEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1943

8. AGE: Years 5 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis H. Allen
13. Birthplace Virginia

MOTHER
14. Maiden Name Lillian Smith
15. Birthplace Washington, D.C.

16 (a) Informant: Louis H. Allen
(b) Address 625 Mosher Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director GEORGE G. KELSON
(b) Address 1303 Presstman Street

Date rec'd by Registrar 11 1948 (b) Huntington Williams, M.D.

151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1948, at 1:50 P.M.

21. I certify that I took charge of the remains described above, held an Ins. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
2dr-3d Burns
752 Body Surface

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 142
(a) Date of injury 11-9-48 at 10:30 A.M.
(b) Where did injury occur? 625 Mosher Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Playing with matches; clothes afire

23. Signature Earl L. Kay M.D.
Medical Examiner.
Date signed 10 Nov 48

G68470 BALTIMORE CITY HEALTH DEPARTMENT G68470
Registered No.

CERTIFICATE OF DEATH

77c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 E. Monument Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES STEPHEN ~~BRYSON~~ Bryson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Merle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1910

8. AGE: Years	Months	Days	If less than one day
38	2	9	hr. min.

9. Birthplace Frostburg, Maryland
(Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER
12. Name James
13. Birthplace Frostburg, Maryland

MOTHER
14. Maiden Name Elizabeth McGreevy
15. Birthplace Frostburg, Maryland

16 (a) Informant Stein Funeral Home
(b) Address Cumberland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory St. Michael
Location Frostburg Md.

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 St. Paul Street

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

NOV 13 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1948 at 7:45 AM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon, and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Kaye M.D.
Medical Examiner.
Date signed 11-11-48

G68471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68471 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. (b) County
(c) City or town Clifton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LONNIE ROBINSON

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/5/1894

8. AGE: Years 53 | Months 11 | Days 5 | If less than one day: hr. min.

9. Birthplace Raleigh, North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace N. C.

MOTHER
14. Maiden Name Alice Rice
15. Birthplace N. C.

16 (a) Informant: Julia Robinson
(b) Address Tifton, Georgia

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/11/48 (month) (day) (year)
(c) Cemetery or crematory
Location Tifton, Ga.

18 (a) Funeral director Joseph E. Locks, Jr.
(b) Address 1344 N. Central Ave

19 (a) NOV 12 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1948 at 12:40 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Uremia Arteriolitis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royster M.D.
Medical Examiner
Date signed 11-10-48

VS 151

G68472

BC-40P-24962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 161a

G68472
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hospital - Caton & Wilkens Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2752 Kinsey Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BABY BOY SCHEUERMANN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/10/48

8. AGE: Years	Months	Days	If less than one day
—	—	0	hr. 3 min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John E.
13. Birthplace Balt Md.

MOTHER
14. Maiden Name ~~Mattie~~ ~~Grote~~ Alberta Kraft
15. Birthplace Balt Md.

16 (a) Informant Mr. John E Scheuermann
(b) Address 2752 Kinsey Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11.11.48 (month) (day) (year)
(c) Cemetery or crematory St. Paul
Location Balto. Md

18 (a) Funeral director Harry N. Witzke
(b) Address 4101 E Monument Ave

19 (a) [illegible] (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1948 to Nov 10 1948 and that I last saw h alive on Nov 10 1948

Immediate cause of death Respiratory failure — Duration

Due to congenital atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo Maxwell
Address St Agnes Hosp Date signed M. D. 11/10/48

VS 152

G68473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

G68473 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Howard
(c) City or town ELKRIDGE (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** RUTH J HANCOCK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 11, 1909

8. AGE: Years 39 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual Occupation CLERK

11. Industry or business BALTO. GAS & ELEC. CO

FATHER
12. Name RUFUS A HANCOCK
13. Birthplace VA

MOTHER
14. Maiden Name MINNIE ANN ROACH
15. Birthplace DELAWARE

16 (a) Informant MRS RUFUS A HANCOCK
(b) Address ELKRIDGE, MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 13 '48 (month) (day) (year)
(c) Cemetery or crematory ST MARY
Location LAUREL, MD.

18 (a) Funeral director Harry H Wiltshe
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williamson Mgr

NOV 11 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1948 at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT 15 1948 to NOV. 10 1948 and that I last saw h-e alive on NOV. 10 1948

Immediate cause of death acute hemorrhagic diathesis - generalized

Due to circulatory failure

Due to acute lymphatic leukemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John White M. D.

Address University Hosp. Date signed 10-10-48

X

G68474

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G68474
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 E. Belvedere Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Thomas Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Widower

6 (b) Name of husband or wife Rose Lee Hughes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1865

8. AGE: Years	Months	Days	If less than one day
83	4	28	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business City Fireman

FATHER
12. Name William Hughes
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine —
15. Birthplace Baltimore

16 (a) Informant G. Lyle Hughes
(b) Address 1955 Sue St., N.W. Washington D.C.

17 (a) Burial (b) Date thereof 11-13-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W. Mt. Royal Ave.
Baltimore 1, Md.

19 (a) NOV 17 1948 (b) 6
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH November 10, 1948, at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6, 1948, to Nov. 10, 1948, and that I last saw him alive on Nov. 10, 1948

Immediate cause of death	Pulmonary Edema	
Due to	Arterio-sclerotic Heart Disease	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Ray E. Brown Jr. M.D.
Address St. Joseph's Hosp. Date signed 11/19/48

VS 150

G68475 ✓ G68475

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3000 KENYON AVE
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 56 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County .....
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 KENYON AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country .....

3 (a) FULL NAME JOHANNA GORCZEWICZ

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED.

6 (b) Name of husband or wife IZYDOR GORCZEWICZ
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) APRIL 13 1873

8. AGE: Years	Months	Days	If less than one day
75	6	26	..... hr. ..... min.

9. Birthplace POLAND. (Town, county, and state)
10. Usual Occupation AT HOME
11. Industry or business

FATHER
12. Name MICHAEL WISNIEWSKI
13. Birthplace POLAND.

MOTHER
14. Maiden Name EVA ?
15 Birthplace POLAND.

16 (a) Informant MARY SWISKOWSKI
(b) Address 3000 KENYON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 12 1948 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location GERMAN HILL ROAD

18 (a) Funeral director THE DIPPEL BROTHERS
(b) Address 1800 E LOMBARD ST.

NOV 11 1948 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 9 1948 at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 4 1948 to NOV 9 1948, and that I last saw h alive on NOV 9 1948.

	Duration
Immediate cause of death Cardio-vascular Renal Chronic nephritis — Uraemia —	4/4/48
Due to Arterio-Sclerosis —	—
Due to	.....
Other Conditions Empyema	—

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify trade or place)
(e) Means of injury —

23. Signature Louis F. Krumm M. D.
Address 722 No. Kenwood Ave. Date signed

VS 189

NOV 10 1948

G68476

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G68476 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Huntingdon (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME MRS. NETTIE SCHOOLDEN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife Mr. Adolph Schoolden
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) April 5, 1897

8. AGE: Years	Months	Days	If less than one day
51	7	4	— hr. — min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Daniel Palmer
13. Birthplace —

MOTHER
14. Maiden Name Carrie Myers
15. Birthplace —

16 (a) Informant (History from Record)
(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Md

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Rd. Balto Md

19 (a) NOV 12 1948 (Date rec'd by Registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1948, at 5 28 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1948 to Nov. 9 1948, and that I last saw her alive on Nov. 9 1948.

Immediate cause of death	Duration
cardio-resp failure	48 hrs
Chronic congestive heart failure	
Due to arterio sclerotic heart disease	
Due to	
Other Conditions Cerebral thrombosis, Pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M. F. Cox M. D.
Address Union Memorial Hosp. Date signed 11-5-48

VS 190

G68477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G68477 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkens Ave

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3731 Garrison Avenue

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Nellie Jeffery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Arthur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25 1899

8. AGE: Years 49 | Months 1 | Days 15th | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Rudasill

13. Birthplace Virginia

MOTHER 14. Maiden Name Mary Baddy

15. Birthplace Virginia

16 (a) Informant Mr. Arthur Jeffery

(b) Address 3731 Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Baltimore County

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road Baltimore, Md.

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) Torrington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 NOV 1948, at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 NOV 1948 to 9 NOV 1948, and that I last saw HER alive on 9 NOV 1948

	Duration
Immediate cause of death Cardio-respiratory failure gastro intestinal bleeding	
Due to CARCINOMA of uterus with metastasis to Rt & Rt lumbar vertebra	
Other Conditions SEVERE anemia MALNUTRITION	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Rafael Ramsay M. D.

Address St. Agnes Hospital Date signed 9 NOV 1948

VS 150

X

668478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 668478

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4031 Belle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4031 Belle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Oshry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Kath Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1766

8. AGE: Years 82 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Samuel
13. Birthplace Russia

MOTHER 14. Maiden Name Luna
15. Birthplace Russia

16 (a) Informant Morris Oshry
(b) Address 4031 Belle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Jack Leurs Inc
(b) Address 2106 Eutaw Place

19 (a) Nov 12 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-12-1948 at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1948 to Nov 12 1948 and that I last saw h e alive on Nov 12 1948

Immediate cause of death Cardiac Decompensation — Duration

Due to Coronary Thrombosis

Due to

Other Conditions Myocarditis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Schapiro M. D.
Address 2028 Eutaw Pl Date signed 11/12/48

VS 150

G68479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G68479 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 15 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4300 Pimlico Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Acelia Plott PLEET

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Jacob (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace Russia Lith (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Lith

MOTHER
14. Maiden Name Not Known
15. Birthplace Lith

16 (a) Informant Jack Pleet
(b) Address 4300 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory Mt. View Memory Lawn
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place

19 NOV 12 1948 (Date rec'd by registrar) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1948 at 5:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1948 to Nov 10 1948 and that I last saw her alive on Nov 10 1948.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Ray E. Pusey Jr. M.D.
Address St. Josephs Hospital Date signed 11/10/48

VS 150

68480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 68480

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PENALTY IMPOSED FOR WILFUL FALSE STATEMENT

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1228 Glyndon ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 Glyndon ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Molly Anna Townsend

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	widow

6 (b) Name of husband or wife late Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1872

8. AGE: Years	Months	Days	If less than one day
76 76	3		hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Grace Conway
(b) Address 1228 Glyndon ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 12 48 (month) (day) (year)
(c) Cemetery or crematory Mount Ridge
Location Pikesville, Md

18 (a) Funeral director Harry A. Little
(b) Address 410 Edmondson ave

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) Interring for Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10/48 19 at 4-30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10/8 19 48 to 11/8/48 19, and that I last saw h[illegible] alive on 11/8/48 19

Immediate cause of death	Duration
Bronchopneumonia	one week
Due to Myocarditis	
Due to Uterine prolapse	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter T. Carter M. D.
Address 410 Edmondson ave Date signed 11/12/48

VS 150

G68481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1318

Registered No. G68481

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, 30 (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 E. Clement St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Helen Elizabeth Hannington (HARRINGTON)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Charles Leo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/18/03

8. AGE: Years	Months	Days	If less than one day
45	8	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Schmidt
13. Birthplace Md.

MOTHER 14. Maiden Name Sadie Baker
15. Birthplace Md.

16 (a) Informant Family
(b) Address Same

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 11-13-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location 2 North Ave.

18 (a) Funeral director James L. McCleary
(b) Address 136 S. Fort Ave.

19 NOV 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1948 at 7:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1948 to Nov 10 1948 and that I last saw her alive on Nov 10 1948

Immediate cause of death	Acute pericarditis	
Due to	Chronic Nephritis	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Acute pericarditis

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl C. Person Jr. M.D.
Address St. Joseph's Hospital Date signed 11/12/48

VS 150

G68382

BALTIMORE CITY HEALTH DEPARTMENT

LCH

CERTIFICATE OF DEATH

181

Registered No. G68382

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4401 Forest View Ave. (If rural give location)
(e) Citizen of foreign country? no. (Yes or No) If yes, name country

3 (a) FULL NAME MARTHA MITCHELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 29, 1880

8. AGE: Years	Months	Days	If less than one day
68	2	11 12	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name William T. Mitchell
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Mary A. Turner
15. Birthplace Delaware

16 (a) Informant Balto. City Hosp. Bertha & Alice Mitchell-4401 Forest View Ave.
(b) Address Baltimore City Hosp. Records 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Rd.

19 NOV 12 1948 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10. 1948 at 2:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9/48 19 to 11/10/48 19 and that I last saw her alive on 11/10/48 19

Immediate cause of death 3rd Degree Burns of Body

Duration 20 Hrs

Due to CERTIFICATION APPROVED BY Howard J. Madden, M.D.

Due to C. J. Fabrikant M.D.
CHIEF OR ASST. MEDICAL EXAMINER

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 11.9.48 at 3 30 PM
(c) Where did injury occur? Baltimore (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Burns from furnace

23. Signature Pinkham MD M. D.
Address Balto City Hosp Date signed 11-11-48

VS 150

G68483

BALTIMORE CITY HEALTH DEPARTMENT

ES-94282

CERTIFICATE OF DEATH 131a

G68483 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 Gilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Fitzpatrick

3 (b) If veteran, name war: WWI
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Katherine.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1865

8. AGE: Years	Months	Days	If less than one day
83	2	11	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Dudley
15. Birthplace Md.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 13 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location Baltimore, Md.

18 (a) Funeral director Wilson & Pierce
(b) Address 1214 Park Ave.

NOV 12 1948 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10 1948 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20 1945 to 11-10 1948
and that I last saw him alive on 11-10 1948

Immediate cause of death: Renal failure — Duration: 1 week

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Reckfeld, M.D.
Address Balto City Hosp. Date signed 11-10-48

VS 153

68384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 526

Registered No. 68384

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5507 Bland ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (~~yrs., mos., or days~~) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or ~~town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5507 Bland ave.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Francis A. Westrich

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W.	Married

6 (b) Name of husband or wife Alice R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-24-1870

8. AGE: Years	Months	Days	If less than one day
77	11	17	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James Westrich
13. Birthplace Ohio

MOTHER
14. Maiden Name Catherine Berkamp
15. Birthplace Unknown

16 (a) Informant Mrs. Alice R. Westrich
(b) Address 5507 Bland Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 11-13-48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) NOV 12 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1948, at 5A M

21. I certify that death occurred on the date above stated, that I attended deceased from April 2 1948, to Nov. 11 1948 and that I last saw h[illegible] alive on Nov. 7 1948.

Immediate cause of death	Duration
Carcinoma Urinary bladder	7 mo.
Due to Uremic Coma	3 days
Due to Suppression of Urine	

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation June 1948
Major findings of operation Malignancy of the bladder
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sherman R. Brant M. D.
Address 2001 Manhattan Ave. Date signed 11/14/48

VS 150

G68485

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G68485

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 Cresmont Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Cresmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE A. SICKEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife George H. Sickel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 19, 1872

8. AGE: Years	Months	Days	If less than one day
76	5	22 23	hr min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward Wilson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary --
15. Birthplace Unknown

16 (a) Informant Mrs. C. F. Butcher
(b) Address 103 Franklin Ave., Silver Spring Md.

17 (a) Burial (b) Date thereof 11/13/48
(Burial, cremation, or removal)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 12 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11/48 19 ~~50~~ M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? White (Negro)?
(d) Means of injury

23. Signature John R Ware M.D.
Medical Examiner.
Date signed 11/12/48

VS 151

68486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68486

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Walkers + Caton Aves.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 29 (If outside city or town limits write RURAL and give town)

(d) Street No. 606 Woodington Rd. (If outside city, give district)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Virginia V. Gale.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-26-1196

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thomas W. Gale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-3-07

8. AGE: Years 41 | Months 2 | Days 8 | If less than one day: hr. min.

9. Birthplace Md. (Kent Co.) (Town, county and state)

10. Usual Occupation School teacher

11. Industry or business Dept. Edu. Balto. City

FATHER

12. Name James Wood dec.

13. Birthplace Md.

MOTHER

14. Maiden Name Nellie Sappington

15. Birthplace Md.

16 (a) Informant Mr. Thomas W. Gale

(b) Address 606 Woodington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)

(c) Cemetery or crematory Wesley Chapel Cem.

Location Rock Hall, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1948 8:10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-9 48, to 11-11 48 and that I last saw h alive on 11-11 48

Immediate cause of death (a) Respiratory failure

Due to (b) Cerebral Hemorrhage

Due to (c) Hypertension

Other Conditions

Duration: 2 days.

Date of operation 11/11/48

Major findings of operation: Cerebral Hemorrhage - left temporal

Findings of autopsy: Hemorrhage left temporal

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 11/11/48

VS 150

68187

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 68187

CERTIFICATE OF DEATH 106B

68187

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Mount Holly Street
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto — (If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Mount Holly St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Peter N. Margaritis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
60 yrs				

9. Birthplace Turkey (Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business

FATHER
12. Name Nick Margaritis
13. Birthplace Turkey

MOTHER
14. Maiden Name Sophia
15. Birthplace

16 (a) Informant James Margaritis
(b) Address 1000 Mount Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Windsor Mill Rd

18 (a) Funeral director Lambros F.H. Inc
(b) Address 438-40 E. North ave

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1948, at 3 a.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to Nov 1948, and that I last saw him alive on Nov. 9 1948

Immediate cause of death	Duration
Cardiac failure	
Due to Bronchial - Cardiac asthma	
Due to Bronchiectasis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation /
Major findings of operation: /
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2301 Kirkwood Pl. Date signed

VS 150

G68488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G68488

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St
(c) Hospital or institution: Good Samaritan Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 4
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 N Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Simmons Anderson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Raymond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 6, 1891

8. AGE: Years 57 | Months - | Days 4 | If less than one day hr. min.

9. Birthplace Bees Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Anderson Simmons
13. Birthplace Va.

MOTHER 14. Maiden Name Mary Savage
15. Birthplace Va.

16 (a) Informant Charles Earl Anderson
(b) Address 1902 N. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13 '48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs. Robt. G. Elliott, Deceased
(b) Address 1129 N. Carlton St

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10, 1948, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5/47 19 to 11/10 19 47.
and that I last saw h[illegible] alive on 11/10 '48.

Immediate cause of death Carcinoma of Ovary — Duration

Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Redding M.D.

Address 4 E. Lafayette St (Date signed 11/12/48)

VS 155

G68489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13-2

G68489 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 Rectory Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 Rectory Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Baker

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 17, 1860

8. AGE: Years	Months	Days	If less than one day
88	8	24	3 hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Henry Baker
13. Birthplace Germany

MOTHER
14. Maiden Name Susanna Baker
15 Birthplace Pennsylvania

16 (a) Informant Mr. Roland Howard
(b) Address 1012 Rectory Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road Balto. Md.

19 (a) NOV 12 1948 (Date rec'd by registrar) Emerson Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1948 at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1948 to Nov. 10 1948, and that I last saw her alive on Nov. 10 1948

Immediate cause of death: Coronary Occlusion — Duration: 1 day
Due to Cardio-renal-vascular Disease
Due to CERTIFICATION APPROVED BY Howard J. Madden, M.D.
Other Conditions C. J. Lubinski M.D.
(Include pregnancy within 3 months of death) CHIEF OR ASST. MEDICAL EXAMINER
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 617 W. 40th St. Date signed 11/10/48

VS 150

G68490 Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68490 Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32 E. Dear St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 32 E. Dear St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosemary Pyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife William J. Pyle

6 (c) If alive, give age years

7 Birth date of deceased (mo., day, yr) 2/7/1856

8. AGE: Years	Months	Days	If less than one day
92	9	10	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Hayman Rudolph

13. Birthplace Germany

MOTHER 14. Maiden Name Rosemary McNaughton

15. Birthplace Ireland

16 (a) Informant Mr Francis Pyle

(b) Address 32 E. Dear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)

(c) Cemetery or crematory Carlin's

Location Rt 2 Frederick Rd

18 (a) Funeral director J. J. Fahey & Sons

(b) Address 1218 Light St

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14/48 19 . at 11:31 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10/20/48 to 11/14/48 and that I last saw h alive on 11/11/48.

Immediate cause of death Coronary thrombosis — Duration 1 day

Due to Arteriosclerosis

Due to Senility — Duration 1 day

Other Conditions Osteoporosis associated with Fracture of left femoral neck & recent acute cystitis — Duration 30 days

(Include pregnancy within 3 months of death)

Date of operation CERTIFICATION APPROVED BY

Major findings of operation:

Howard J. Madison

of autopsy: CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence Oct 19 48 at ? M

(c) Where did injury occur? Home (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? Kitchen

(e) Means of injury Fell through old floor in

23. Signature Isaac Miller M.D. M. D.

Address 1225 Cleveland St Date signed 11/14/48

VS 150

G68491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G68491

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PENALTY IMPOSED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 700 W. 40th St.

(c) Hospital or institution: Home for Incurables

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos 10 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 700 W. 40th St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Sula Norris Hooper

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband ~~or wife~~ Thomas D. Hooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 14, 1869

8. AGE: Years	Months	Days	If less than one day
79	4	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife formerly.

11. Industry or business NONE

FATHER 12. Name John C. Norris

FATHER 13. Birthplace Lancaster Co., Va

MOTHER 14. Maiden Name Susan D. Rogers

MOTHER 15. Birthplace Baltimore Co., Md.

16 (a) Informant Home for Incurable Records-M.F.O.

(b) Address 700 W. 40th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Balto. Md.

18 (a) Funeral director Stewart & Madden Co.

(b) Address 101 W. North Av. - Balto-1

19 NOV 12 1948 (b) [illegible] Registrar

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1948, at 4.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1940, to 11/12 1948, and that I last saw h[illegible] alive on 11/11 1948.

Immediate cause of death Generalized Abdominal Carcinomatosis ?

Duration 6 months

Due to

Due to

Other Conditions Arthritis Deformans

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

12 years.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. Grafton Hershberger M. D.

Address 214 Medical Arts Bldg Date signed 11/12/48

068492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

068492 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 - E - North Ave
(c) Hospital or institution: at home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2) USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 E North Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? Life years

3 (a) FULL NAME Eugene Ludwig Renner

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Divorced

6 (b) Name of husband or wife: Mary E. Nergert
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 23 1871

8. AGE: Years 77 | Months 3 | Days 18 | If less than one day: hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired
11. Industry or business none

FATHER
12. Name Geo. P. Renner
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Suring
15. Birthplace on Atlantic Ocean

16 (a) Informant Mr. C. L. Renner (Bro.)
(b) Address 309 E North

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Stuart Morgan Co.
(b) Address 108 W Mt Royal Ave

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10th 1948, at 12:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1947, to Nov. 10th 1948, and that I last saw h/m. alive on Nov. 10 1948.

Immediate cause of death: Myocarditis — Duration: Several years

Due to: Arteriosclerosis — Duration: Unknown

Due to: .....

Other Conditions: .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ferdinand L. Ries, M.D.
Address 24 S. Broadway Date signed 11/10/48

VS 3

68393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 68393

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 W. Barre Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: CHARLES BIDDLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife: Sadie Biddle (dec'd)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1875

8. AGE: Years	Months	Days	If less than one day
73	4	11	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: James Biddle
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Jennett Sorrell
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Clarence Biddle
(b) Address: 615 W. Barre Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn Cem.
Location

18 (a) Funeral director: Mrs Katie R Williams
(b) Address: 322 N. Schroeder St

19 (a) NOV 12 1948 (Must be registered by registrar) (b) Huntingtown, Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10 1948, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: C. F. Jubrondt M.D. Medical Examiner.
Date signed 11/11/48

VS 151

G68494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ Registered No. G68494

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Lombard Sts
(c) Hospital or institution: Univ. Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4311 Liddell Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr Walter Eigner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Cassandra Eigner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 20, 1888

8. AGE: Years	Months	Days	If less than one day
60	2	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Jacob Eigner
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Hottes
15. Birthplace Maryland

16 (a) Informant Gladys A. Eigner
(b) Address 4311 Liddell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director John A. Mozan
(b) Address 3000 E. Balt. St.

19 NOV 12 1945 (Date rec'd by registrar) (b) Thurston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1945 to 11-13 1945, and that I last saw him alive on 11-10 1945

Immediate cause of death: pulmonary embolism. a coronary thrombosis

Due to — Rt Sided hemiplegia arteriosclerosis

Due to

Other Conditions (Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard E. Tull M. D.
Address Blue Ridge Summit Date signed 11-10-45

VS 150

G68195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G68195
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2815 Clifton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 Clifton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Fell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry Fell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 17, 1877

8. AGE: Years 71 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Barnat Etzel
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth ?.
15. Birthplace Germany

16 (a) Informant Henry Fell
(b) Address 2817 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director John G. Moran
(b) Address 3000 E. Balt. St.

19 (a) NOV 12 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11 1948, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1948 to 11/10 1948 and that I last saw her alive on 11/10 1948.

Immediate cause of death
Carcinoma of stomach with obstruction

Due to General carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/22/48

Major findings of operation: Carcinoma of stomach

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A L Hornstein
Address 204 E. Biddle St Date signed 11/13/48

VS 150

668496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 120

Registered No. 668496

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 S. Conkling Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Stanton Daggert Hughes JR.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-24-3309

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 6, 1928.

8. AGE: Years	Months	Days	If less than one day hr.	min.
20	6	4		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business Works for Crocker Union

FATHER
12. Name Stanton D. Hughes Sr.
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Minnie Shorty.
15. Birthplace Balto Co., Md.

16 (a) Informant Stanton D. Hughes Sr.
(b) Address 918 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-48. (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location 7225 Eastern Ave

18 (a) Funeral director Charles S. Zeiler
(b) Address 901 S. Conkling St.

19 (a) Nov 12 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1948, at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30/ 1948 to 11/10/ 1948, and that I last saw him alive on 11/10/ 1948.

Immediate cause of death Uremia — Duration

Due to Subacute Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence , at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Roy E. Pearson Jr. M.D.
Address 1 E. Hoffman St. Date signed 11/10/48

VS 150

68497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 68497

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4207 Springdale Ave.
(c) Hospital or institution:
Virginia Lewis Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Springdale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Julia Evans

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Henry Cecil Evans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 26, 187[illegible]

8. AGE: Years	Months	Days	If less than one day
70	-	16	hr. min.

9. Birthplace Cedar Falls, Iowa
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Theodore Imhoff
13. Birthplace Canton, Ohio

MOTHER
14. Maiden Name Julia Higgins
15. Birthplace Lexington, Kentucky

16 (a) Informant Mr. Percy T. Shaw
(b) Address 4608 Weddon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director T. Willis Lamsman
(b) Address 4510 Liberty Heights Ave.

19 (a) Nov 1 1948 (b) Turnington Williams, M.D.
Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1948, at 1:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1936 to Nov 1 1948.
and that I last saw h[illegible] alive on Nov. 2 1948

Immediate cause of death	Duration
Carcinoma of Pleura	6 mos.
Due to Carcinoma of Breast	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1942
Major findings of operations: Ca of Breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin W. Lamsman, M. D.
Address [illegible] St. Paul St. Date signed 11-2-48

668198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 668198

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3853 Forest Park ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3853 Forest Park ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May A. Tregor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John D. Tregor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1869

8. AGE: Years	Months	Days	If less than one day
79	5	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Vincent Ramey
13. Birthplace Germany

MOTHER
14. Maiden Name Vein
15. Birthplace Germany

16 (a) Informant Miss Miriam Schmidt
(b) Address 4019 Chatham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13, 1949 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Ellis Lamonaco
(b) Address 4510 Liberty Heights ave.

19 (a) Nov 12 1949 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1949, at P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from March 16 1942 to Nov. 10, 1949 and that I last saw her alive on Nov. 10, 1949

Immediate cause of death
Coronary Thrombosis
Due to Coronary Arteriosclerosis
Due to Hypertensive Cardio-Vascular Disease
Due to Generalized Arteriosclerosis
Other Conditions

Duration
½ hr.
20 months
?
?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip F. Lerner
Address 5401 N. Port ave. Date signed 11/11/49

VS 150

X

668199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668199 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3639 Poland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days) 54yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3639 Poland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert L. Pinker.

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower.

6 (b) Name of husband or wife Fannie M. Pinker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1874

8. AGE: Years	Months	Days	If less than one day
74	9	16	hr. min.

9. Birthplace Virginia. (Town, county, and state)
10. Usual Occupation Painting
11. Industry or business

FATHER 12. Name George Pinker.
13. Birthplace Virginia.

MOTHER 14. Maiden Name Elizabeth Yeasbroad
15. Birthplace Virginia

16 (a) Informant Mr. Parker Pinker.
(b) Address 3637 Poland Ave

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Nov 15/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge.
Location Pikesville, Md.

18 (a) Funeral director Austin E. Donovan
(b) Address 3638 Poland Ave

19 Nov 12 1948 Huntington Williams MD
(Signature and title of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1948 at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1948 to 11/11 1948 and that I last saw h[illegible] alive on 11/11 1948

Immediate cause of death Cerebral Hem
Hemiplegia — Duration 24 hrs

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 2020 N. Clare Date signed 11/12/48 M.D.

VS 150

668500

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92c

Registered No. 668500

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5406 Gerland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine MacCubbin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 24-1888

8. AGE: Years 60 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name John G. Niederspahn
13. Birthplace Md

MOTHER 14. Maiden Name Margaret Blotkarp
15. Birthplace Md

16 (a) Informant Mrs. Robert MacCubbin
(b) Address 5406 Gerland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Luck
(b) Address 5305 Harford Rd

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) Interment Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12 1948, at 5 15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 11/2 1948, to 11/12 1948, and that I last saw her alive on 11/12 1948.

Immediate cause of death Rheumatic toxic Stenosis
Bronchopneumonia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Rheumatic toxic Stenosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marjorie Okeson, M.D. M. D.
Address Sinai Hosp. Baltimore Date signed 11/12/48

VS 150

Dr. Speed
11 E. Chase Street

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95B

Registered No. 68501

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 204 West Franklin Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 West Franklin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Langrill

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Henry J. Langrill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Apr. 18, 1892

8. AGE: Years	Months	Days	If less than one day
56	6	22	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name James Mac Cormack
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridgett Smyth
15 Birthplace Ireland

16 (a) Informant Mrs. Frederick Bach
(b) Address 540 Winston Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-348 (month) (day) (year)
(c) Cemetery or crematory New Cathdral
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 NOV 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1948 at 9 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1947 to November 9 48, and that I last saw h[illegible] alive on 11/9 1948.

Immediate cause of death Acute pulmonary edema — Duration

Due to Bilateral, bronchopneumonia

Due to Rheumatic heart disease

Other Conditions Atrophic arthritis, Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. L. Speed M.D.
Address 11 E. Chase St. Date signed 11/10/48

VS 159

Dr. Grossfeld
5402 Belair

668502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

668502 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3105 White Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 White Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence M. Cier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Andrew W. Cier
6 (c) If alive, give age (years)

7. Birth date of deceased (mo., day, yr) Apr. 21, 1884

8. AGE: Years 64 | Months 6 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name ? Dittlemar
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Andrew Cier
(b) Address 3105 White Avenue #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) NOV 12 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1948 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 - 1948 to Nov. 11 1948; and that I last saw h[illegible] alive on Nov. 11 1948.

Immediate cause of death: Cerebral Hemmorhage — Duration: 5 days
Due to: C.V.D. decreased
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature Richard J. Grossfeld, M.D.
Address 5402 Belair Date signed 11-11-48

VS 150

G68503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68503

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Bon Secours Hospital

(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4701 Sehley Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mr. Frederick G. Gibmeyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	M.

6 (b) Name of husband or wife Mrs. Dorothy Gibmeyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25-1908

8. AGE: Years	Months	Days	If less than one day
40	2	18	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Bethl Steel Co.

FATHER 12. Name Wm. Gibmeyer

13. Birthplace Md.

MOTHER 14. Maiden Name Rose

15. Birthplace Md

16 (a) Informant Mrs. Dorothy Gibmeyer

(b) Address 4701 Sehley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-48 (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director Leonard D. Luck

(b) Address 5305 Harford Rd.

NOV 12 1948 Huntington Williams, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12/48 19 . at 1.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1948, to 11/12 1948, and that I last saw him alive on 11/11 1948.

Immediate cause of death	Duration
Sub-Arachnoid Hemorrhage	
Due to (Spontaneous)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William S. Womack M D

Address Bon Secours Hosp. Date signed 11/12/48

VS 150

68504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. 68504

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bethlehem Steel-Sparrows Pt. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2416 Lombard Street (West) (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MELVIN KARL KEEHNER

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 28, 1908

8. AGE: Years 40 | Months 3 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Supervisor

11. Industry or business Bethlehem Steel Company

FATHER
12. Name Daniel H. Keehner
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth M. Meyer
15. Birthplace Germany

16 (a) Informant Mary J. Medinger
(b) Address 2416 W. Lombard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto., Maryland

18 (a) Funeral director George L. Eckhardt
(b) Address 2101 Frederick Ave

19 (a) NOV 12 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1948 at 9:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Rogers M.D. Medical Examiner
Date signed 11-12-48

VS 181

G68505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68505

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 20 days
(e) Length of stay in Baltimore (yrs., mos., or days): 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Me. (b) County: Saco
(c) City or town: (If outside city or town limits, write RURAL and give town)
(d) Street No.: Tasker St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: ALBERT CHARLES GRACE

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW 2	yes- ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 28, 1927

8. AGE: Years	Months	Days	If less than one day
21	8	15	hr. min.

9. Birthplace: NY (Town, county, and state)
10. Usual Occupation: Messman
11. Industry or business: Seafarer

FATHER
12. Name: Walter Grace
13. Birthplace: Me.

MOTHER
14. Maiden Name: Sophie Fritzbung
15. Birthplace: Pa.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16-48 (month) (day) (year)
(c) Cemetery or crematory: Saint Mary's
Location: Biddeford Maine

18 (a) Funeral director: E Haworth Armistead
(b) Address: 3911 Liberty Heights Ave

19 (a) (Date rec'd by Registrar) (b) Transit or Burial Permit Issued by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 12 1948 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1948 to Nov. 12 1948 and that I last saw him alive on Nov. 12 1948.

Immediate cause of death	Duration
Hodgkins Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: James B Dukes, M. D.
Address: U S Marine Hosp Date signed: 11/12/48

668506

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92E

Registered No. 668506

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3129 Abell Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3129 Abell Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH R. KEENE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Adelia Jane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1858

8. AGE: Years	Months	Days	If less than one day
90	9	12	hr. min.

9. Birthplace Madison, Dorchester Co., Md. (Town, county, and state)
10. Usual Occupation Carpenter, Retired
11. Industry or business

FATHER
12. Name Josiah Keene
13. Birthplace Md

MOTHER
14. Maiden Name Freces Frazier
15 Birthplace Md

16 (a) Informant Mrs. Herbert Ireland
(b) Address 3129 Abell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)
(c) Cemetery or crematory Church Creek Episcopal
Location Dorchester Co., Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19. (a) NOV 13 1948 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1948 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1948 to Nov 11 1948. and that I last saw h alive on Nov 11 1948.

Immediate cause of death Myocarditis

Due to (a)

Due to (b) Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify one)
(e) Means of injury

23. Signature John F. Cain M. D.
Address 612 N 40 St Date signed

VS 150

68507

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 68507

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 Beachwood Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BRICE E. WALTON, Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1929

8. AGE: Years	Months	Days	If less than one day
19	7	5	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business C. A. Walton

FATHER
12. Name Brice E. Walton
13. Birthplace Virginia

MOTHER
14. Maiden Name Maude V. Shiflette
15. Birthplace Virginia

16 (a) Informant Burnee Walton
(b) Address 1512 Stengel Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Charlottsville, Virginia

18 (a) Funeral director ROLAND L. FISHER
(b) Address 5112 Dundalk Ave

19 (a) NOV 13 1948 Huntington Williams, M.D. Registrar
Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1948, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of Skull
Shock & Internal Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-12-48 at 12:25 P. M.
(b) Where did injury occur? New N. Point Rd. & Wise Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Motorcycle and Bus Collision

23. Signature Emil Beyl M.D.
Medical Examiner
Date signed 11-12-48

VS 131

G68508

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93E

Registered No. G68508

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Key Highway--American Sugar
(c) Hospital or institution: Refinery

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ERNEST (SUMMERFIELD) SOMMERFIELD

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 350-05-7702

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W	M	Married

6 (b) Name of husband or wife: Augusta

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) November 15, 1891

8. AGE: Years	Months	Days	If less than one day
(D.M.) 56	11	28	hr. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual Occupation: Maritime Guard

11. Industry or business: Long Shoremans Union

FATHER
12. Name: Frank Sommerfield
13. Birthplace: Germany

MOTHER
14. Maiden Name: Augusta Locach
15. Birthplace: Germany

16 (a) Informant: Augusta Sommerfield
(b) Address: 111 N. Stricker Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13-1948 (month) (day) (year)
(c) Cemetery or crematory: Glen Haven
Location: Md

18 (a) Funeral director: Pratt C. Walters
(b) Address: Pratt & Stricker Sts

19 NOV 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 19 48 at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Ind. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Pulmonary Edema

Due to: Acute congestive heart failure

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature Carl L. Royer M.D.
Medical Examiner

Date signed 11/12/48

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 668509

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 Bridgeview Road
(c) Hospital or institution: Residence
(d) Length of stay in hospital or inst. (yrs., mos., or days) none.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs +.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County City
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 923 West Franklin St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Fleming Jackson Deceased 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1775 [illegible]

8. AGE: Years 73 | Months 2 | Days 2 | If less than one day hr. 2 min.

9. Birthplace Lancaster County, VA (Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name ? —
13. Birthplace —

MOTHER
14. Maiden Name Felisciah Williams
15. Birthplace Lancaster County, VA.

16 (a) Informant Mrs Julia Miller
(b) Address 923 West Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location [illegible]

18 (a) Funeral director A. Halgrad & Edmund Funeral
(b) Address 9 E. Lemmon St.

19 (a) NOV 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 12 1948, at 9:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Called to Pronounce Dead 19 to 19 .
and that I last saw h — alive on — 19 —.

Immediate cause of death Cardiac Failure — Duration

Due to Senility

Due to

Other Conditions Arterio Sclerotic Heart Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerry E. Luck, M.D. M D
Address 303 Bridgeview Date signed 11-12-48

VS 150

162 R

66851.0

M M.- 122411

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

✓ 66851.0 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTOMORE CITY HOSPTIALS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 MO.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 LLEWELYN AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMANUEL WADE.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 8, 1900

8. AGE: Years	Months	Days	If less than one day
48yrs.	5	2	hr min

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name RALPH WADE.
13. Birthplace MD.

MOTHER
14. Maiden Name MATILDA GROSS.
15. Birthplace MD.

16 (a) Informant BALTO. CITY HOSP. RECORDS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-48 (month) (day) (year)

(c) Cemetery or crematory MD. Calvary
Location Baltimore

18 (a) Funeral director A. Halsted
(b) Address 918 Light St.

19 (a) NOV 12 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/48 19 at 330 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25/48 19 to 11/10/48 19 and that I last saw him alive on 11/10/48 19

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary tuberculosis	4-5yrs.
Due to	
Other Conditions Carcinoma of colon (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: Pulm tbc + Ca of colon

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external cause(s), fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Earle Burton, M.D.
Address Baltimore City Hospitals Date signed 11/11/48

VS 150

12E

668511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

668511
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317- Madeira Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1317- Madeira Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha McRae

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, age years

7. Birth date of deceased (mo., day, yr.) ? ? 1882

8. AGE: Years 66 | Months | Days | If less than one day: hr min

9. Birthplace N. C. (Town, county, state)

10. Usual Occupation unemployed

11. Industry or business ?

FATHER
12. Name George ?
13. Birthplace N. C.

MOTHER
14. Maiden Name Lee
15. Birthplace N. C.

16 (a) Informant Sarah Ingram
(b) Address 1078- Argyle Ave

17 (a) Burial, cremation, or removal Shipped (b) Date thereof 11-13-48 (month) (day) (year)
(c) Cemetery or crematory Wadesboro, N. C.
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Edmondson Ave

19 (a) Nov 13 1948 (b) Registrar
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9-1948 hr M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 1948, to Nov. 1948, and that I last saw her alive on 11-8 1948

Immediate cause of death (a) Chronic endocarditis — Duration

Due to

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell
Address 118 Dolphin St. Date signed 3-1948 M. D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

925

VS 150

668512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

Registered No. 668512

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1201 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (REV.) SAMUEL DEWEY WASHINGTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1904

8. AGE: Years	Months	Days	If less than one day
44	5	10	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name Samuel Washington
13. Birthplace Lemont, Pa.

MOTHER
14. Maiden Name Belle Mahone
15. Birthplace Virginia

16 (a) Informant Mrs. Evelyn Washington
(b) Address 1819 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9 1948 at 8:18 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1948 to 11-9 1948.
and that I last saw him alive on 11-9 1948

Immediate cause of death: Cerebral Hemmorhage
Agut Stroke
Due to Stroke

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1 wk

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Wilbur Phillips M.D.
Address 1543 Penna Ave Date signed 11-11 48

VS 153

668513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 668513

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1238 Etting Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst., (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days 55 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1238 Etting Street (If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME WILLIAM HENRY HARRIS JR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mathilda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1872

8. AGE: Years 76 Months 3 Days 28 If less than one day hr. min.

9. Birthplace Ellicott City, Maryland (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER 12. Name William H. Harris

13. Birthplace Maryland

MOTHER 14. Maiden Name Miranda Miller

15. Birthplace Maryland

16 (a) Informant Mrs. Mathilda Harris

(b) Address 1238 Etting Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Pk.

Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) NOV 13 1948 (Date rec'd by registrar) (b) Registrar for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1948 at 9:00 M

21. I certify that death occurred on the date above stated, that I attended deceased from 7-10 1948 to 11-11 1948 and that I last saw h alive on 11-11 1948

Immediate cause of death — Duration

Coronary Heart Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. D.

Address 561 Date signed 11-12-48

VS 153

The 68514

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 68514

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 ½
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Druid Hill Ave. (If rural, give location) 15 yrs.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (REV.) JULIUS CAESAR PAROLA

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella Mildred Parola
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1885

8. AGE: Years 62 | Months 10 | Days 15 16 | If less than one day: hr. min.

9. Birthplace British West Indies (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name Julius C. Parola
13. Birthplace British West Indies

MOTHER
14. Maiden Name Uknown
15. Birthplace

16 (a) Informant Ella Mildred Parola
(b) Address 2202 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 13 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10 1948 at 5 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 1928 1948 to 11/10 1948.
and that I last saw h[illegible] alive on 11/10 94[illegible]

Immediate cause of death: Coronary Occlusion — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clark Kelly M.D.
Address 74 Druid Hill Ave. Date signed 11/11/48

VS 150

668515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 668515

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5107 Underwood Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5107 Underwood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME PHILIP M. OSBORNE

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Harriet Jarvis Osborne
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Feb. 26, 1901
8. AGE: Years 47 | Months 8 | Days 15 | If less than one day hr. min.
9. Birthplace Madison Lodge, Kan. (Town, county, and state)
10. Usual Occupation Certified Public Accountant
11. Industry or business

FATHER
12. Name George Osborne
13. Birthplace Kansas, Missouri

MOTHER
14. Maiden Name Nena C. Crawford
15. Birthplace Missouri

16 (a) Informant Mrs. Harriet Jarvis
(b) Address 5107 Underwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 13 1948 (Date received) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17th 1942 to Nov. 11th 1948, and that I last saw him alive on Nov. 11th 1948.

Immediate cause of death: Myocardial Insufficiency — Duration: 2 yrs.
Due to Coronary Insufficiency — Duration: 6 yrs.
Due to Coronary occlusion — Duration:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter E. Stempler M. D.
Address 817 Medical Arts Bldg. Date signed 11.12.48

VS 150

668516

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668516 Registered No. 12R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 Dryden Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 708 Dryden Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA MAY SEDBERRY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Osoar L. Sedberry
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Sept. 3, 1869

8. AGE: Years	Months	Days	If less than one day
79	2	9	hr. min.

9. Birthplace Green Castle, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Rush Crunkleton
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Margaret Barnhart
15. Birthplace Pa.

16 (a) Informant Mr. R. Archie Phebus
(b) Address 708 Dryden Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 12 1948 (b) Registrar
(Date received by registrar)

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1948 to Nov 11 1948; and that I last saw h- alive on Nov 11 1948

Immediate cause of death
Pulmonary tuberculosis — Duration 2 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dewey C Russell
Address 3902 Roseland Ave Date signed 11/12/48

G68517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47

Registered No. G68517

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Marylend
(b) Street address 822 E. Eager St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life Time

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

2 (a) **FULL NAME** James A. Slaysman

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elizabeth Bailey Slaysman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13, 1885

8. AGE: Years 62 | Months 10 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Car Repairman
11. Industry or business at B & O. R.R. Shop.

FATHER
12. Name Alexander Slaysman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary McCusker
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Elizabeth Slaysman
(b) Address 822 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4302 Ed Frederick Rd

18 (a) Funeral director Edwin W. Coughlin
(b) Address 924 E. Eager St.

19 (a) NOV 13 1948 (Date received by registrar) Hunterton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1948 at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948 to Nov 12 1948.
and that I last saw him alive on Nov 12 1948

Immediate cause of death	Duration
Carcinoma Left Lung	7 months
Due to	
Due to	
Other Conditions Carcinomatosis	2 months

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hart M. D.
Address 1631 E. North Ave Date signed 11/12/48

V S 150

668518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 72 B

Registered No. 668518

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light Street

(c) Hospital or institution: So. Balto. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1308 Sargeant St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William J. Wheeler

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5th 1904

8. AGE: Years 44 | Months 7 | Days 7 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Plumber Inspector

11. Industry or business Baltimore City

FATHER — 12. Name William J. Wheeler

FATHER — 13. Birthplace Baltimore Md.

MOTHER — 14. Maiden Name Mary Welsh

MOTHER — 15. Birthplace Ireland

16 (a) Informant Mrs Helen L. Wheeler

16 (b) Address 1308 Sargeant St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/48 (month) (day) (year)

17 (c) Cemetery or crematory London Park Cem.

Location 3801 Frederick Ave

18 (a) Funeral director John J. Lowman & Son

18 (b) Address 901-03 Hollins St.

19 (c) NOV 13 1948 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1948 at 2:50 M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 11, 1948 to Nov. 12 1948 and that I last saw him alive on Nov. 12, 1948.

Immediate cause of death: Hemorrhagic Diathesis — Duration: 4 days

Due to

Due to

Other Conditions: None (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Massive hemorrhage [illegible]

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Marion C. Bailey, Jr. M.D.

Address So. Balto. Gen. Hosp. Date signed 11/14/48

G68519

BALTIMORE CITY HEALTH DEPARTMENT

AUMON CERTIFICATE OF DEATH 46

Registered No. G68519

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address [redacted]

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2730 Gwynn's Falls Pky. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John A Aumon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Lucy C. Aumon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 20, 1869

8. AGE: Years	Months	Days	If less than one day
79	6	21	22 hr. min.

9. Birthplace Hanover Pa. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace Penna.

MOTHER

14. Maiden Name King

15. Birthplace Penna.

16 (a) Informant Mr. Milton L. Aumon

(b) Address 2500 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15/48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery. Location Baltimore Md.

18 (a) Funeral director Mamie Cook Syfer

(b) Address 1900 West North Ave.

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams Mc

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1948, at 3 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Novemb 6 48 to Nov 11 1948, and that I last saw him alive on 11 - 11 - 1948.

Immediate cause of death carcinoma of rectum

Due to terminal stage of carcinoma of rectum

Due to

Other Conditions Hypertensive CVD

(Include pregnancy within 3 months of death)

Date of operation 10 - 13 - 48

Major findings of operation: Carcinoma of rectum

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes; fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John A. Rosser M D

Address University Hosp Date signed 11-11-48

VS 150

G68520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G68520 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1803 Thornbury Rd.

(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1808 Park Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** JAMES W. HARRY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elizabeth E. Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1870

8. AGE: Years	Months	Days	If less than one day:
78	7	23	4 hr. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER
12. Name David G. Harry
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Maria Warner
15. Birthplace Harford Co., Md.

16 (a) Informant Mrs. Elizabeth E. Harry
(b) Address 1808 Park Ave.

17 (a) Cremation (b) Date thereof 11/13/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount Crem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 13 1948 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1948, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1948 to 11/13 1948.
and that I last saw him alive on 11/13 1948.

Immediate cause of death: Generalized arterial sclerosis.

Duration: 7

Due to

Due to

Other Conditions Bronchostasis
arteriosclerotic heart disease.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature George W. Armistead Jr. M. D.

Address 114 St. Paul St. Date signed 11/13/48

VS 150

668521

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 668521

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp — 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give county)
(d) Street No. 105 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Limerick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife Feb. 3, 1878

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1878

8. AGE: Years 70 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired Machinist

11. Industry or business Mor - Sinclair & Scott

FATHER
12. Name ? ?
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name ? ?
15. Birthplace Balto., Md.

16 (a) Informant Robt. V. Limerick (Son)
(b) Address 23 E. Front Ave. Balto 39 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month, day, year) Mon. Nov. 15, 1948

(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director G. Howard Evans
(b) Address 1400 E. Eager St. (30) Huntington Williams, Mr.

NOV 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Nov. 1948 at 8:21 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Hypertensive Cardio-Vascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kanwisher, M.D. Medical Examiner.
Date signed 11 Nov. 48

VS 151

668522 Huber

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 D

Registered No. 668522

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 Cypress St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or day's)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Cypress Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura L. Huber

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/9/1877

8. AGE: Years	Months	Days	If less than one day
71	8	3	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Frederick Taube
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Germany

16 (a) Informant: Family
(b) Address Same

17 (a) B (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn

18 (a) Funeral director James L. McCarthy
(b) Address 130 East Fort Ave.

19 NOV 13 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Nov. 1948, at 6:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hamner, M.D. Medical Examiner.
Date signed 12 Nov. 48

VS 151

668523

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 668523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 Valley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Valley St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Margaret Mary Zeigler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm. H. Zeigler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1890

8. AGE: Years	Months	Days	If less than one day
58	3	19	12 hr. min.

9. Birthplace Irelaand (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Retican
13. Birthplace Irelaand

MOTHER
14. Maiden Name Bridget Kelly
15. Birthplace Ireland

16 (a) Informant Mr. Zeigler
(b) Address 1307 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rite Wiedefeld
(b) Address 900 East Biddle St

19 NOV 13 1948 (b) Huntington Volunteer, Md. Registrar
(Date received by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Nov 1948, at 4:04 M

21. I certify that death occurred on the date above stated, that I attended deceased from — 1937 to 12 Nov 1948, and that I last saw h alive on 11 Nov 1948

Immediate cause of death: Anemia — Duration: 5 days

Due to Cystic-transuden - renal [illegible] hypertension + arteriosclerosis — ? ?

Due to Diabetes — 4 years 10 yrs.

Other Conditions: Gangrene L left. heel
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Samuel Zeigler M.D.
Address 714 E. Preston Date signed 13 Nov 48

VS 150

668524

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

668524 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Roche

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced S.

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1863

8. AGE: Years	Months	Days	If less than one day: hr.	min.
84	10	14		

9. Birthplace W. Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Va Ludlow
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Lillie Linton / in Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1948 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 Nov 13 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1948, at 9:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1948 to Nov 12 1948, and that I last saw h alive on Nov 11 1948.

Immediate cause of death — Duration

Edema Lungs — 1 day
Due to Chronic Myocarditis — 5 yrs
Due to
Other Conditions Arteriosclerosis — 5 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature E. Gill Dial M. D.
Address 163 E Vow St Date signed Nov 12 48

VS 150

G68525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G68525 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St
(c) Hospital or institution:
Hospital for the Women of Md.
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 6 11
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 84

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 John St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Mary Brewer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~April~~ 2 1865 ~~Not Known~~

8. AGE: Years	Months	Days	If less than one day
83	7	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edmund H. Brewer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Julia (Not Known)
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Thomas L. Berry
(b) Address 12 Pine Drive Towson 4 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave

18 (a) Funeral director Wm Oakley Inc.
(b) Address 1217 St Paul St

NOV 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1948, at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1948, to Nov 13 1948, and that I last saw her alive on Nov 12 1948.

Immediate cause of death Cerebrovascular accident — Duration ~~yr~~ ~~mo~~ ~~da~~

Due to Hypertensive Cardio vascular Disease

Due to

Other Conditions Pneumonia, Left Lower Lobe
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pneumonia, an abscess.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mark E. Hall Jr. M. D.
Address Hosp. Women of Md Date signed 11/13/48

VS 150

G68526

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

Registered No. G68526

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1927 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSE C. COOPER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Louis
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1882

8. AGE: Years: 66 | Months: | Days: | If less than one day: hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name (Unknown) Baker
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Frank L. Fisher
(b) Address 704 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

NOV 14 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1948 19 . at 8:30 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 48 to 19 48 and that I last saw her alive on 11 Nov 19 48

Immediate cause of death: Carcinoma rt. breast with metastasis — Duration: 3 years

Due to

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Jay M Zamonema
Address 2050 Linwood Ave. Date signed 13 Nov. 48 M D

VS 150

48-25-45 G68527 A-6-6-6-95

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159 ✓ G68527 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 S. Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby-Boy Nowacki

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-11-48

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Nowacki
13. Birthplace Md.

MOTHER 14. Maiden Name Marie Rutkowski
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 14 1948 (month) (day) (year)
(c) Cemetery or crematory ST STANISLAUS
Location DUNDALK AVE

18 (a) Funeral director DIPPEL BROTHERS
(b) Address 1800 LOMBARD ST.

NOV 14 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. - 13 1948 at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11- 1948 to 11-13- 1948 and that I last saw h alive on 11-13- 1948

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. O. Goldstein

Address Johns Hopkins Hosp. Date signed 11/13/48 (M.D.)

VS 150

668568

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92D

Registered No. 668568

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner ave + Dukeland st.
(c) Hospital or institution West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-7-21
(e) Length of stay in Baltimore (yrs., mos., or days) 61 years

2. USUAL RESIDENCE OF DECEASED:
(d) State Maryland (g) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3615 Lucille Ave. (If rural give location)
(e) Citizen of foreign country? Russia (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Annie Zeskind

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: ~~M~~ W

6 (b) Name of husband or wife Morris | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1877

8. AGE: Years 71 | Months | Days | If less than one day: hr. | min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Henry — 13. Birthplace Russia

MOTHER — 14. Maiden Name Henna Fagn — 15. Birthplace Russia

16 (a) Informant Louis Zeskind
(b) Address 3712 Garfield St NW Wash DC

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Windsor Mills Road

18 (a) Funeral director Jack Lewis, Inc
(b) Address 1660 Eutaw Place

19 (a) [illegible] (State registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1948, at 1 55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1948, to 11/13 1948, and that I last saw her alive on 11/13 1948

Immediate cause of death: Cerebral vascular accident — Duration

Due to: Hypertensive Cardio-vascular disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Blunt Trauma MD

23. Signature West Baltimore General Hosp
Address Date signed Nov. 19, 1948

G68529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68529

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Lombard Sts
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Beechgrovville Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Marie Boring

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
F	W	Married

6 (b) Name of husband or wife Sidney C Boring
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr) Unknown

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business own home

FATHER
12. Name Littleton P Brown
13. Birthplace Virginia

MOTHER
14. Maiden Name Florence L Henry
15. Birthplace Virginia

16 (a) Informant Sidney C Boring
(b) Address Brentwood Md. R.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 16/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Carroll Co Md

18 (a) Funeral director Edw C Tipton
(b) Address Hampstead Md

19 (a) NOV 14 1948 (Date received by registrar) Wellington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13 1948 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1948 to 11-13 1948, and that I last saw him alive on 11-13 1948

Immediate cause of death: Intestinal obstruction — Duration

Due to Phlebitis left leg

Due to Sarcoma of stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard E Hall M.D.

Address Univ. Hosp. Date signed 11-13 1948

VS 153

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68530 ✓ G68530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2011 McCulloh Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 McCulloh Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME HATTIE DeCOURSEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 29, 1897

8. AGE: 51 Years | 4 Months | 12 Days | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Columbus DeCoursey
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Celeste Saxton
15. Birthplace St. Mary's Co. Md.

16 (a) Informant Miss Mary DeCourcey
(b) Address 2011 McCulloh Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1948 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 14 1948 (Date received by registrar) (Signature of registrar)

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1948 at 3:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1948 to Nov 11 1948.
and that I last saw h alive on Nov 11 1948

Immediate cause of death: Chronic Glomerular Nephritis — Duration: Couple years

Due to: Uremia

Due to:

Other Conditions: Hypertension and Cardiac Disease — Couple years

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R J Young

Address 4724 C Baltimore Md Date signed 11/13/48 M D

G68531

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G68531
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3313 Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5212 Spring Lake Way
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME. Edwin Mitchell Sturtevant (Edwin Mitchell Sturtevant)

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-05-6704

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs Edwin M. Sturtevant
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1887

8. AGE: Years 61 | Months 4 | Days 29 | If less than one day: hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER
12. Name Frank Sturtevant
13. Birthplace New Jersey

MOTHER
14. Maiden Name Hattie Hart
15. Birthplace New York

16 (a) Informant Mr. C. E. Sturtevant (Son)
(b) Address 13 Ballo 4.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stewart & Company
(b) Address 108 W Road Av.

19 (a) NOV 14 1948 (Date rec'd by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1948 at 10:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1946 to Nov. 12 1946 and that I last saw him alive on Nov. 12 1946.

Immediate cause of death	Duration
Coronary thrombosis	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature [signature] M D
Address U. M. H. Date signed 4/12/48

VS 150

668532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117B

Registered No. 668532

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 333 N Charles St

(c) Hospital or institution: Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days

(e) Length of stay in Baltimore (yrs., mos., or days) 29 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Va. (b) County

(c) City or town Portsmouth (If outside city or town limits, write RURAL and give town)

(d) Street No. 624 Douglas Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mrs. George Williams

3 (b) If veteran, name war ?

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs. George Williams

6 (c) If alive, give [illegible] years

Rebecca L/ Williams

7. Birth date of deceased (mo., day, yr) April 4, 1908

8. AGE: Years	Months	Days	If less than one day
40	7	9	hr. min.

9. Birthplace New York (Town, County, and state)

10. Usual Occupation Auto Salesman

11. Industry or business Auto Salesman

FATHER

12. Name Mrs. George Williams

13. Birthplace

MOTHER

14. Maiden Name Helen Lorkeitz

15. Birthplace

16 (a) Informant Wife

(b) Address 624 Douglas Ave - Portsmouth Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 14 1948 (month) (day) (year)

(c) Cemetery or crematory

Location Portsmouth Va.

18 (a) Funeral director William J. Tickner & Sons

(b) Address North & Pennsylvania Aves.

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1948 at 7:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1948 to Nov 13 1948 and that I last saw him alive on Nov. 13 1948

Immediate cause of death Uremia

Due to Pneumonia + Peritonitis

Due to abscess Duodenal ulcer (resected)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-18-48 - Abd. Exploration

Major findings of operation: 11-1-48 - Subphrenic + Pneumatic abscess

of autopsy:

Duration

PHYSICIAN Underline the cause to which it should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence No at M

(c) Where did injury occur? No (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? No While at work? (Specify type of place)

(e) Means of injury No

23. Signature George O. Thomas M. D.

Address 333 N Charles St Date signed 11-13-48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68533

J1 - 121681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G68533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anita Marzuserini or Anita Marzucchini

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife late Ferruggio

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1885

8. AGE: Years	Months	Days	If less than one day
63	7	22	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Giuntoli
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 322 S. High St.

19 (a) NOV 15 1948 (Date rec'd by registrar) Hampton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 19 48 at 5.20 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 19 48 to Nov. 13 19 48. and that I last saw h er alive on Nov. 13 19 48.

Immediate cause of death	Duration
Carcinoma of Cervix Generalized metastases	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman J. Carl M.D.
Address 1910 Eastern Ave Date signed Nov. 13 1948

VS 150

G68534 D.C. 48-28620

BALTIMORE CITY HEALTH DEPARTMENT

Hospital Disposal CERTIFICATE OF DEATH 159

Registered No. G68534

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Mcean

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-4-48

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name William Mcean
13. Birthplace Va.

MOTHER 14. Maiden Name Ruth Webster
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) NOV 15 1948 (Date rec'd by registrar) Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1948 at 7 57 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1948 to 11-5 1948. and that I last saw him alive on 11-5 1948.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan C Brennan M. D.
Address Johns Hopkins Date signed 11-6-48

G68535 Hospital C - 48 - 24366 Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

✓ Registered No. G68535

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 Bounty Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl "Dora" Shears

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-8-48

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation: Child

11. Industry or business

FATHER
12. Name: Dora Shears
13. Birthplace: Va

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1948 at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8-1948 to 11-10-1948, and that I last saw her alive on 11-10-1948

Immediate cause of death: Cong. atelectasis

Due to: Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Long M. D.
Address Johns Hopkins Hosp Date signed 11-11-48

VS 150

G68536 ~~G68534~~ ~~H-BC-48-23517~~ Grem

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G68536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 6527 Cleveland ave (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country .....

3 (a) FULL NAME Baby Boy Baughman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 11-1-48

8. AGE: Years	Months	Days	If less than one day
		8	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER — 12. Name Jessie Baughman

13. Birthplace ?

MOTHER — 14. Maiden Name Gwendolyn ?

15. Birthplace ?

16 (a) Informant .....

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory .....

Location .....

18 (a) Funeral director .....

(b) Address .....

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9- 1948, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8- 1948, to 11-9- 1948, and that I last saw him alive on 11-9- 1948.

Immediate cause of death ..... Duration

Conq. atelectasis

Due to .....

Due to Prematurity

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature A. C. Young M D

Address Johns Hopkins Hosp. Date signed 11-11-48

VS 150

G68537 BC - 48-2260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68537

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Whitaker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-6-1948

8. AGE: Years | Months | Days | If less than one day: 7 hrs min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Dorothy Ball
13. Birthplace Md

MOTHER — 14. Maiden Name Alfaei Whitaker
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) NOV 15 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1948 at 6 30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 11-6-1948 to 11-6-1948 and that I last saw h alive on 11-6-1948

Immediate cause of death: Asphyxia — Duration

Due to: Atelectasis

Due to: Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Hang M D
Address Johns Hopkins Hosp. Date signed 11-9-48

VS 150

G68538
JL -123842

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46F

Registered No. G68538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1941 Sponson St. -30 (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME L. Nannie Parks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph (D) Parks

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) March 23, 1879

8. AGE: Years 69 | Months 7 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Va. (Culpeper Ct.) (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business Music Uniform Co.

FATHER
12. Name Joseph Stone
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Simms
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15/48 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave

18 (a) Funeral director Krauss Funeral Home
(b) Address 216 D. Charles St.

19 (Filed) NOV 15 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1948 at 10.30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 18 1948 Nov. 10 1948, and that I last saw her alive on Nov. 10 1948

Immediate cause of death: Cerebrovascular accident — Duration: 2 days

Due to

Due to

Other Conditions: Carcinoma of gall bladder & local extension
(Include pregnancy within 3 months of death)

Date of operation 10/26/48

Major findings of operation: Carcinoma of gall bladder & extension to liver, and peritoneum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman F. Cole M.D.

Address 1772 Eastern Avenue Date signed 11/15/48

VS 150

82a

668539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668539

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SOPHIE GOLDBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. Age: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Moses
13. Birthplace Russia

MOTHER
14. Maiden Name Minnie
15. Birthplace Russia

16 (a) Informant Mrs. Ethel Klauber
(b) Address 2910 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)

(c) Cemetery or crematory
Location New York, N. Y.

18 (a) Funeral director Jack Reves Inc
(b) Address 2406 Eastern Ave Baltimore, Md.

19 (a) (Name filed by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14 1948 at 12 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1948 to 11-14 1948
and that I last saw her alive on 11-14 1948

Immediate cause of death Bronchopneumonia — Duration

Due to Cerebral Thrombosis

Due to

Other Conditions Old hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Home Date signed 11-14-48

VS 150

C68540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. C68540

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1033 W. Lombard St.
(c) Hospital or institution: 18 03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1033 W. Lombard St. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** Arthur W. Smith

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212-12-5372

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edith Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1887

8. AGE: Years 61 | Months 6 | Days 26 25 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Druggist

11. Industry or business Retired

FATHER
12. Name John J. Smith
13. Birthplace Mass.

MOTHER
14. Maiden Name Elizabeth Wagner
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Elizabeth Smith
(b) Address 1033 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director John T. Stansbury
(b) Address 2700 Edmondson Ave.

19 (a) NOV 15 1948 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1948 at 3.30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 11 1948 to Nov 12 1948 and that I last saw him alive on Nov 12 1948

Immediate cause of death	Duration
Myocardial degeneration - insufficiency	Several Years.
Due to arteriosclerotic heart disease with cardiac hypertrophy & congestive failure	
Due to Generalized arteriosclerosis	
Other Conditions Gangrene of toes, left foot following infections and Suppurative paronychia. (Include pregnancy within three months of death)	3 weeks

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Michel, M. D.
Address 2901 Edmondson Ave Date signed Nov 13 1948

VS 150

X

G68541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68541

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1235 W. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1235 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Junita C. G. Tynes

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-9624

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Marride

6 (b) Name of husband or wife Louis Tynes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 20, 1901

8. AGE: Years	Months	Days	If less than one day
47	3	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Gantt
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Cooper
15. Birthplace Md.

16 (a) Informant Mr. Louis Tynes
(b) Address 1235 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) NOV 15 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH November 12, 1948 at 12-30

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 8 1948 to Nov. 12 1948, and that I last saw her alive on Nov. 12 1948

Immediate cause of death: Cerebral Hemorrhage, left, (Paralysis of whole right side) — Duration: 4 days

Due to Undetermined

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] McDonald, M.D.
Address 344 N. Carey St. Date signed 11/13/48

VS 150

G68542 BC 24091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G68542 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Avenue
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15.07
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 16 (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2217 Ashburton St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Girl Stein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1948

8. AGE: Years	Months	Days	If less than one day
		1	hr. min

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Leonard Stein
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rosalie Stein
15. Birthplace Baltimore

16 (a) Informant Rosalie Stein
(b) Address 2217 Ashburton Street

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Science NOV 9 1949

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Evington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct, 28, 1948 at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1945 to Oct 25 1948, and that I last saw her alive on Oct 25 1945

Immediate cause of death Subarachnoid Hemorrhage — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Subarachnoid Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sydney L. Warren M.D.
Address Sinai Hospital Date signed Nov 4 1948

G68543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68543

BC-48-16021 160a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument ST. and Rutland Ave.
(c) Hospital or institution:
Sinai Hospital of Baltimore, Inc.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W.Va. (b) County
(c) City or town Parkersberg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Girl Cooley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1948

8. AGE: Years	Months	Days	If less than one day
		1/2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name C. D. Fore
13. Birthplace Not Known

MOTHER
14. Maiden Name Clara B. Cooley
15. Birthplace West Virginia

16 (a) Informant Clara B. Cooley
(b) Address Parkersberg, W. Virginia

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Local Johns Hopkins Medical Schoo NOV 9 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 15 1948 (b) Huntington Williams, M.D.
(Date filed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1948 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death
a Atherosclerosis
b Coronary Thrombosis
Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Duration
a -
b
c
d

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen L. Koppelman M.D.
Address 817 St. Paul St Date signed 11/5/48

G68544 82-48-21872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G68544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution:
Sinai Hospital of Baltimore INC
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 08
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5731 Edgemark Rd.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Boy Boellner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1948

8. AGE: Years	Months	Days	If less than one day
			22 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Otto Carol Boellner
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Peggy Wax
15. Birthplace Virginia, [illegible]

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo NOV 9 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1948 at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1948 to Oct 9 1948.
and that I last saw him alive on Oct 9 1948.

Immediate cause of death Prematurity

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan G. Wolinsky M. D.
Address Sinai Hosp. Date signed 11-9-48

668545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668545

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Glen Burnie (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Second Ave. S.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret M. Lee

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Harry G. Lee Sr.
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr) March 25, 1889

8. AGE: Years	Months	Days	If less than one day
59	7	18	hr. min.

9. Birthplace Snow Hill, Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Own Home

FATHER
12. Name Edward T. Maddox
13. Birthplace Near Princess Ann, Md.

MOTHER
14. Maiden Name Mary A. Miller
15. Birthplace Near Salisbury, Md.

16 (a) Informant Harry G. Lee Sr.
(b) Address 209-2ND. Ave. S.W. Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) Nov 15 1948 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13 1948, at 4:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11-48 1948 to 11-13 1948, and that I last saw h[illegible] alive on 11-13 1948

Immediate cause of death Pulmonary Embolism — Duration

Due to Hypostasis

Due to

Other Conditions Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address University Hospital Date signed 11-13-48

G68546 B.C. 48-24698

BALTIMORE CITY HEALTH DEPARTMENT ✓ X G68546
Registered No.

CERTIFICATE OF DEATH 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Hrs days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 16 · Box 213A Zone 21
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Beal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	infant

6 (b) Name of husband or wife O

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5, 1948

8. AGE: Years	Months	Days	If less than one day
		1½	hr. min.

9. Birthplace University Hospital
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Clyde Beal
13. Birthplace Warren, Ohio

MOTHER
14. Maiden Name Clara May Morrow
15. Birthplace Ambridge, Pa.

16 (a) Informant Mother
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School NOV 11 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1948, at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1948 to 11-7 1948, and that I last saw her alive on 11-7-1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Congenital heart disease - deformity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben Beal M. D.
Address University Hosp Date signed 11-7-48

VS 150

X

G68547 3C-48-2372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G68547

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Linden Ave & Madison St

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 5635 Loftician Rd #12
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Burbage

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wht.	S

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1948

8. AGE: Years	Months	Days	If less than one day
0	0	0	2 hr. 16 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Hugh Lynn Burbage
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Ogle Burch
15. Birthplace Oakley, Md.

16 (a) Informant Hugh Lynn Burbage
(b) Address 5635 Loftician Rd #12

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (month) (day) (year)

(c) Cemetery or crematory ____
Location University Medical School NOV 8 1948

18 (a) Funeral director Commissioner of Health
(b) Address ____

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2 1948. 6.40 p. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1948, to 11-2 1948, and that I last saw him alive on 11-2 1948.

Immediate cause of death Prematurity — Duration

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: Prematurity

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [signature] M. D.

Address Md. Gen. Hosp. Date signed 11-8-48

VS 180

G68548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68548 Registered No.

BC-48-24462 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Greene Sts.

(c) Hospital or institution: University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 508 Greene St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Bradley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	

6 (b) Name of husband or wife Sam Bradley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/27/48

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Baltimore
(Town, county and state)

10. Usual Occupation Infant

11. Industry or business

FATHER

12. Name Sam Bradley

13. Birthplace

MOTHER

14. Maiden Name Rosalie

15. Birthplace

16 (a) Informant Rosalie Bradley-mother

(b) Address 508 S. Greene St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School NOV 11 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3 1948, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2 1948, to 11/3 1948 and that I last saw her alive on 11/3 1948

Immediate cause of death	Duration
Atelectasis	
Due to Prematurity	
Due to	
Other Conditions Atelectasis Diarrhea	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Pneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)

(e) Means of injury

23. Signature Nicholas Mallis M.D.

Address Univ. Hosp. Date signed 11/10

VS 150

G68549

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G68549

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED.
(a) State W. Va. (b) County
(c) City or town Bluefield (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Bluefield Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME N. Walter Snipe

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex Male | **5. Color or race** White | **6 (a) Single, married, widowed, or divorced** ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 65? | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business Unknown

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) **(b) Date thereof** (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 8 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1948, at 7 A. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A.S.C.V.D.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl K. Royer M.D. Medical Examiner.
Date signed 11/14/48

VS 151

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68550
Registered No.

IS-122486

10

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Metcalf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Div.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 8, 1908

8. AGE: Years	Months	Days	If less than one day
40	6	24	hr. min

9. Birthplace Maine
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER | FATHER
12. Name Lee Metcalf
13. Birthplace Maine

MOTHER
14. Maiden Name Gertrude Watt
15. Birthplace Maine

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 11 1948

18 (a) Funeral director Commissioner of Health
(b) Address

1948 NOV 15 (Date rec'd by registrar) (by) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2 1948 at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1948 to 11-2 1948 and that I last saw h[im] alive on 11-2 1948

Immediate cause of death - PROBABLE
(1) PULMONARY EMBOLISM
Due to Rt. LOWER LOBE
(2) DISSEMINATED POLYNEURITIS
Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: NO

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Warren E. Cotton M. D.
Address Balto City Hospital Date signed 11/10/48

VS 153

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68551

Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G68551

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33[illegible] & Charles St
(c) Hospital or institution: Union Memorial Hosp 9 01
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Old York Rd (If rural give location)
(e) Citizen of foreign country? O (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Herbert Harrington

3 (b) If veteran, name war	3 (c) Social Security Account No.
? W	? NWC

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mrs Edith Harrington
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Feb. 2, 1877

8. AGE: Years	Months	Days	If less than one day
71	9	12	..... hr. ..... min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation - Painter
11. Industry or business - none

FATHER
12. Name James Harrington (deceased)
13. Birthplace England

MOTHER
14. Maiden Name Harriet Bailey (deceased)
15. Birthplace England

16 (a) Informant Mrs Edith Harrington
(b) Address 3804 old york Rd - Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cath
Location Baltimore Co Md

18 (a) Funeral director Wilhoyte
(b) Address 1217 Ft Ave

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Interment or Cremation

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14- 1948 at 7.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1948, to 11-14 1948.
and that I last saw him alive on 11-14 1948

Immediate cause of death	Duration
Cerebro - Vascular Accident	
Due to	
Due to	
Other Conditions Fractured Rt Femur. (Include pregnancy within 3 months of death)	

Date of operation 11-(2-4
Major findings of operation: Wm. H. Hammer, M.D.
of autopsy: Per

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 11-2-48 at 10. A M
(c) Where did injury occur? Balt, Maryland (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify) While at work? no
(e) Means of injury Fell from window

23. Signature Frank Supplee, Jr. M. D.
Address Union Memorial Hosp Date signed 11-14-48

VS 15

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

File referred by chief medical Examiner
G68552

Medical Examiner's Case
BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68552
Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga + Calvert Sts.
(c) Hospital or institution: Mercy Hosp. Ward 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No: 2217 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Alverda Grosty

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Nathaniel G
6 (c) If alive, give age (years)
7. Birth date of deceased (mo., day, yr): Oct 26 1870
8. AGE: Years 78 | Months 0 | Days 18 | If less than one day: hr. 19 min.
9. Birthplace: Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Samuel Smith
13. Birthplace: Md.

MOTHER
14. Maiden Name: Laura Griffith
15. Birthplace: Md.

16 (a) Informant: Nathaniel Grosty
(b) Address: 2217 Maryland Ave
17 (a) Burial, cremation, or removal: Burial (b) Date thereof: 11/16/48 (month) (day) (year)
(c) Cemetery or crematory: Irmo Ridge
Location: Simpsonville, S.C.
18 (a) Funeral director: Wilson & Lee
(b) Address: 1217 E. Fort Ave
19 (a) Nov 15 1948 (Date rec'd by registrar) (b) Hunting for Williamson, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14-1948, at 4:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11-1948 to 11-14-1948 and that I last saw her alive on 11-14-1948.

Immediate cause of death: Acute cardio respiratory failure — Duration

Due to: Chronic Heart failure

Due to: Hypertension, arteriosclerosis, senile changes

Other Conditions: Pathological findings, see protocol

(Include pregnancy within 3 months of death)

Date of operation: CERTIFICATION APPROVED BY Wm. H. Kemmer, M.D. Per Carl L. Rupp

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: ?
(a) Accident, ~~suicide, or homicide~~
(b) Date of occurrence 11-10-48 at ? P.M.?
(c) Where did injury occur? Balto., Balto., Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home
(Specify) (Place) While at work?
(e) Means of injury: Slipped and fell to floor Fracture of R. femur

23. Signature C. D. Thomas, Jr. M.D.
Address Mercy Hosp. Date signed 11-14-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 100

G68553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G68553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 2101
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Burgundy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN HIPPLER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1895

8. AGE: Years	Months	Days	If less than one day
53 yrs.		14	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Andrew Hippler
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Market
15. Birthplace Germany

16 (a) Informant Mrs. Lilly E. Martin
(b) Address 310 Germania Ave., Schenectady 7, New York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Avenue

18 (a) Funeral director Howard N. Blight, Jr.
(b) Address 6009 Harford Road

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1948, at 7:25PM

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection thereon and from the evidence obtained by said Autopsy / Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L. Rzyski M.D. Medical Examiner
Date signed November 11, 1948

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G68554

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68554

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hos ital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-01
(e) Length of stay in Baltimore (yrs., mos., or days) 19-01

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 N. Calhoun Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: ALBERT ROBINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Middlesex County, Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Walter Robinson
13. Birthplace Virginia

MOTHER
14. Maiden Name Peachie Winkfield
15. Birthplace Virginia

16 (a) Informant Richard Toliver
(b) Address Fairfield, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof nov 17/1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto. Co. Md.

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry St

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Registration No. [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1948 at 11:45 PM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive arteriosclerotic cardio-vascular disease
Acute c ngestive heart failure
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Earl L. Rogers M.D. Medical Examiner.
Date signed 11-11-48

VS 151

G68556 — 2 copy of duct

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46

G68555 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution:
S.B.G.H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Walton

3 (b) If veteran, name war —

3 (c) Social Security Account No. 169-09-8487

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 20 1886

8. AGE: Years 62 | Months 8 | Days 9 | If less than one day: hr. 21 min.

9. Birthplace [redacted]
(Town, county, and state)

10. Usual Occupation laborer

11. Industry or business —

FATHER
12. Name Nathaniel Walton
13. Birthplace Alabama

MOTHER
14. Maiden Name Lucy Hurley
15. Birthplace N. C.

16 (a) Informant
(b) Address

17 (a) Burial
(Burial, cremation, or removal)
(b) Date thereof Nov 15-1948
(month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry St

19 NOV 15 1948 (b)
(Date rec'd by registrar) Huntington Woods Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14/48 1948 at 1134 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1948 to 11/14 1948, and that I last saw him alive on 11/14 1948.

Immediate cause of death Shock — Duration 1 hr

Due to Hemorrhage

Due to Evisceration

Other Conditions Ca. Head of Pancreas + metastases
(Include pregnancy within 3 months of death)

Date of operation 11/13/48

Major findings of operation: Ca. Head of Pancreas + metastases

of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan E. Trevaskis M. D.
Address 1213 Light St Date signed 11-15-48

Allan E. Trevaskis 128

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G68556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G68556

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Huggins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mamie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7-30-75

8. AGE: Years 73 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace NC (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Alexander Huggins
13. Birthplace NC

MOTHER
14. Maiden Name Mary Seldon
15. Birthplace NC.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 16 48 (Month) (Day) (Year)
(c) Cemetery or crematory Balto. Nat. Cem.
Location

18 (a) Funeral director Mrs. Elliott & Daughter
(b) Address 1129 N. Carrollton

19 Nov 15 1948 (Registered by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1948, at 9 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10-1948 to 11-12-1948 and that I last saw him alive on 11-12-1948.

Immediate cause of death: Unknown. — Duration:

Due to: Pneumonia Rul. 3 days

Due to: ? Cerebrovascular accident. } 5 days

Other Conditions: Parkinsons disease } PHYSICIAN

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Dr. Thenmann

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Calkins
Address Jo. H. Hosp. Date signed 11/12/48
E. Calkins X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Medical Examiner Case 668557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G68557

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Broadway and Fairmount Ave.
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County:
(c) City or town: Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1212 S. Decker St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Mrs. Frances Rusin

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife: George H. Rusin
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12-24-1885

8. AGE: Years	Months	Days	If less than one day: hr.
62	10	20	

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual Occupation: House-Keeper
11. Industry or business:

FATHER
12. Name: Frank Bayner
13. Birthplace: Germany

MOTHER
14. Maiden Name: Josephine —
15. Birthplace: Poland

16 (a) Informant: Record
(b) Address: Church Home and Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart
Location: Glenmar Hill Rd

18 (a) Funeral director: Selby Zeh-Co
(b) Address: 463 S. Monroe St

19 Nov 15 1948 (Date received by Registrar) Huntington Williams, M.D. (Signature of Registrar)

CERTIFICATION APPROVED BY: Henry J. Mascia, M.D. for JOHN R. DAVIS, M.D. CHIEF OR ASST. MEDICAL EXAMINER

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-13 1948, at 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13 1948, to 11-13 1948, and that I last saw her alive on 11-13 1948

Immediate cause of death: Respiratory arrest — Duration: 30 min.

Due to: ~~Cerebro vascular Accident~~ Acute Subdural hematoma — Duration: 4½ hrs.

Due to: fall in home

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy: Acute Subdural hematoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 1/1
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence: 13 Nov 48 at 1:15 P M
(c) Where did injury occur? Baltimore (City or town) (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No inside
(e) Means of injury: Fall on stairs

23. Signature: Richard M. Garrett M. D.
Address: Church Home & Hospital Date signed: 11-13-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. G68558

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 ~~(Hartford Terrace)~~ Lake Montebello Terrace
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ERNEST MERSON

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Molly Merson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1905

8. AGE: Years 43 | Months 3 | Days 22 | If less than one day: hr. min.

9. Birthplace Howard Co., Md.
(Town, county, and state)

10. Usual Occupation Plaster

11. Industry or business

FATHER
12. Name Frank Merson
13. Birthplace Howard Co.

MOTHER
14. Maiden Name Agnes Smith
15. Birthplace Howard Co.

16 (a) Informant Molly Merson
(b) Address 2119 ~~(Hartford Terrace)~~ Lake Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17, 1948 (month) (day) (year)
(c) Cemetery or crematory Savage Cemetary
Location Howard Co., Md.

18 (a) Funeral director Ridgely Selby
(b) Address Laurel, Maryland

19 (a) NOV 15 1948 (Date rec'd by registrar) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1948 19 . at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun shot wound, Right Temple

Due to

Other Conditions Marked Depression

(Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 14, 1948 approx. 1:30 A.M.
(b) Where did injury occur? 2119 ~~(Hartford Terrace)~~ Lake Montebello Terrace
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature John R Dawn, M.D.
Medical Examiner
Date signed 11, 15, 48

VS 181

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. 68559

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: WEST BALTIMORE GEN. HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 PUPLAND ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** CHARLES W. HAEGERICH

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-01-8555

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife IDA (ROLLMAN)

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr) MAY 30, 1886

8. AGE: Years 62 | Months 5 | Days 14 | If less than one day hr. — min.

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation MECHANIC

11. Industry or business

FATHER
12. Name ALBERT HAEGERICH
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name ELIZABETH WALTERS
15. Birthplace BALTIMORE, MD.

16 (a) Informant MRS CHARLES W. HAEGERICH
(b) Address 1502 PUPLAND ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11/13/48 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

19 (a) NOV 15 1948 (Rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Nov 1948, at 1:44 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Nov 1948, to 13 Nov 1948, and that I last saw h[illegible] alive on 13 Nov 1948.

	Duration
Immediate cause of death Carcinoma of the body of the pancreas	
Due to Hepatic insufficiency	1 wk
Due to metastatic carcinoma	?
due to: carcinoma of the body	
Other Conditions of the pancreas	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. P. Young, M.D.
Address W. B. & Hospital Date signed 13 Nov 48

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 668560

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
University Hospital 18 2W
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1055 W. Lexington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA GRANT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1896

8. AGE: Years	Months	Days	If less than one day
52	8	-	hr. min.

9. Birthplace Cristfield, Maryland
(Town, county, and state)

10. Usual Occupation Housefife

11. Industry or business

FATHER
12. Name Charles Weeks
13. Birthplace Cristfield, Maryland

MOTHER
14. Maiden Name Maggie Weeks
15. Birthplace Cristfield, Maryland

16 (a) Informant Alfonzo Weeks
(b) Address Baltimore, Maryland

17 (a) Burial (b) Date thereof Nov. 16-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Cristfield Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Beverly ave

19 (Date rec'd by registrar) NOV 15 1948 Lexington Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1948, at 1:39 P M

21. I certify that I took charge of the remains described above, held an Insp. & inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to Hypertensive C.V. disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sobrinski M.D.
Medical Examiner.
Date signed 11/11/48

VS 151

X

G68561

BC- 48-27673

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157a

Registered No. G68561

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catons & Wilkins ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Walker

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 11, 1948

8. AGE: Years | Months | Days | If less than one day: 14 hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation New born
11. Industry or business

FATHER
12. Name John W. Walker
13. Birthplace

MOTHER
14. Maiden Name Rita Lloyd
15. Birthplace Md

16 (a) Informant John Walker
(b) Address 2614 W. Franklin St

17 (a) Buried (b) Date thereof 11/15/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Sabatorio
(b) Address 1827 W. North Ave
NOV 15 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1948, at 9:25 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Respiratory failure
Duration:
Due to: a Cardiac failure.
Due to: Extrema hydrocephalus
Other Conditions: large Spina bifida
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Osvald Nagwell M.D.
Address St Agnes Hosp Date signed 11/13/48

Geo. A. MacConnell X

VS 150

668562 BC-48-1968 X ✓ 668562

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 182a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 7309 Hughes Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN J. HANEY, JR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1948

8. AGE: Years	Months	Days	If less than one day
	2	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John J. Haney, Sr.
13. Birthplace Drake, S. C.

MOTHER
14. Maiden Name Margaret Bittorf
15. Birthplace Baltimore, Md.

16 (a) Informant John J. Haney, Sr.
(b) Address 7309 Hughes Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11- -48 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edgn Ave
18 (a) Funeral director Geo H. Leimbach
(b) Address 1-28 N Fremont St

19 (a) Date received by registrar NOV 15 1948 (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1948, at 2.50a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Mechanical Suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-14-48 at approx. 2.00 p. M.
(b) Where did injury occur? 7309 Hughes Ave. Sparrows Point
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Mechanical suffocation due to bedclothes

23. Signature Earl Rye M.D.
Medical Examiner.

Date signed November 15, 1948

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68563

1226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 59yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 N. Streeper Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Emil Morawski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen Morawski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1871

8. AGE: Years	Months	Days	If less than one day: hr.	min.
77	10			

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business

FATHER
12. Name Marion Morawski
13. Birthplace Poland

MOTHER
14. Maiden Name Victoria Smuzinska
15. Birthplace Poland

16 (a) Informant Helen Morawski
(b) Address 701 N. Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-48 (month) (day) (year)
(c) Cemetery or crematory. Holy Rosary
Location Balto Co.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

19 NOV 15 1948 Date rec'd by Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1948, at 9:10 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 11/8/ 1948 to 11/13/ 1948, and that I last saw him alive on 11/13/ 1948.

	Duration
Immediate cause of death Cardio-respiratory failure	
Due to Generalized peritonitis	7 days
Due to Gangrene of bowel from thrombus and mesentaric	1 wk.
Other Conditions Arteriosclerosis occlusion	

(Include pregnancy within 3 months of death)

Date of operation 11-8-48
Major findings of operation: Obstruction c. gangrene of bowel
of autopsy: Generalized Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) (While at work?)
(e) Means of injury

23. Signature J. Joseph Kaye, M.D.
Address 1400 N. Caroline Date signed 11-13-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 668564

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 61
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daisy Lee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8-10-92

8. AGE: Years	Months	Days	If less than one day
56	2	-	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Grace Fisher
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15-1948 (month) (day) (year)
(c) Cemetery or crematory National
Location Frederick Ave. Balto. Md.

18 (a) Funeral director Barron Thomas & Knight
(b) Address 725 Gilmor St. Baltimore, Md.

1948 NOV 15 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1948, at 10 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1948, to 11-10 1948, and that I last saw her alive on 11-10 1948

Immediate cause of death: Tuberculous pneumonia — Duration

Due to Ruptures bronchial lymph node

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: TB pneumonia, R lob

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature John Collins Harvey M. D.
Address Johns Hopkins Hospital Date signed 11-11-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G68565

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

931

Registered No. G68565

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 Ashburton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Ashburton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Z. Roland (George Zebulon Roland)

3 (b) If veteran, name war: none

3 (c) Social Security Account No.:

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mamie M. Roland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 17, 1875

8. AGE: Years 73 | Months 1 | Days 27 | If less than one day: hr. min.

9. Birthplace: Kent Co., Md. (Town, county, and state)

10. Usual Occupation: Butcher - retired

11. Industry or business:

FATHER
12. Name Enoch Allen Roland
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant: Mrs. Sydney H. Raab
(b) Address 3006 Du Boise Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11/17/48 (month, day, year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 15 1948 (Date received by Registrar) **(b)** Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Nov. 1948, at 10:47 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions Pernicious Anemia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D. Medical Examiner
Date signed 14 Nov. 48

Form VS 151

Please write clearly with pen and ink. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G68566

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170c

G68566 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 15 07

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2609 N. Hilton Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH Jennings TROTT

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 214-26-9323

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Doris K. Trott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1896

8. AGE: Years	Months	Days	If less than one day
51	11	5	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Retired Police Officer
11. Industry or business

FATHER
12. Name: Thomas Trott
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Sarah McDevitt
15. Birthplace: Ireland

16 (a) Informant: Mrs. Doris K. Trott
(b) Address: 2609 N. Hilton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)
(c) Cemetery or crematory: Balto. National Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: WILLIAM J. TICKNER & SONS
(b) Address: North & Pennsylvania Avenues

19 (a) (Date rec'd by registrar) (b) Tickner for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1948, at 8:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 1517
(a) Date of injury 11-13-48 at 8:19 A. M.
(b) Where did injury occur? Hilton St. & Piedmont Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian struck by auto

23. Signature: George T. Merrill, M.D. Medical Examiner
Date signed 11-13-48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G68567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

Registered No. G68567

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN MICHAEL STREB

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	~~Married~~

6 (b) Name of husband or wife Mary A. (nee McDonald)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 4, 1913

8. AGE: Years	Months	Days	If less than one day
35	1	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business U. S. Industrial Chemical

FATHER
12. Name John A. Streb
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth C Hennessie
15. Birthplace Balto. Co.

16 (a) Informant Mrs. Mary A. Streb
(b) Address 3139 Belmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (c) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

19 NOV 15 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1948, at 1:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, ~~suicide~~ ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet Wound of Brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. at ? M.
(b) Where did injury occur? Gwynn Falls Stream
(c) Did injury occur at home, on farm, industrial place, in public place? Public (While at work?) No
(d) Means of injury Firearms

23. Signature [signature] Medical Examiner. M.D.
Date signed 11/15/48

EM

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

668568
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. This correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Luvenia Bertha Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Charles R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Oct. 12, 1875

8. AGE: Years: 73 | Months: 1 | Days: 1 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business

FATHER
12. Name: William Bell
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Mary L. Patterson
15. Birthplace: Baltimore

16 (a) Informant: Mrs. Ida May Myers
(b) Address: 1712 Broadway.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: North Ave & Rose St.

18 (a) Funeral director: Clarence F. Hoffmann
(b) Address: 1639 Broadway.

19 (a) NOV 16 1948 Registered by (Signature of Registrar): Hunter for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 13, 19 48, at 1 30 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 19 48 to Nov 13 19 48, and that I last saw h alive on Nov 13 19 48

Immediate cause of death: Lobular Pneumonia — Duration: 2 days

Due to: Ch. Bronchitis

Due to: Ch. Sepsis

Due to: Ch. Valvular Heart Disease — 4 yrs

Other Conditions: Chron. Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: C. W. Myers Dr

Address: 1580 E. 33rd Date signed: 11/15/48

G68569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1178

X 18 G68569 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Hampstead
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Woodem

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ or wife Carrie Anthony

6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Nov 11-1875

8. AGE: Years 73 | Months — | Days 7 | If less than one day hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Manager

11. Industry or business Dairy Business

FATHER 12. Name Calvin E Woodem

13. Birthplace Md

MOTHER 14. Maiden Name Samantha Mackey

15. Birthplace Md

16 (a) Informant Mrs Lawrence Woodem

(b) Address Hampstead Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16/48 (month) (day) (year)

(c) Cemetery or crematory Hampstead
Location Carroll Co Md

18 (a) Funeral director Edw C Upton

(b) Address Hampstead Md

19 (a) (b) Washington Williams, M.D. Registrar
(Date received by Registrar) NOV 15 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1948 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 13 1948, and that I last saw h[illegible] alive on Nov 13 1948.

Immediate cause of death Hemorrhage & Circulatory Shock — Duration

Due to Gastric Bleeding

Due to Duodenal Ulcer

Other Conditions Pneumonitis Left Base

(Include pregnancy within 3 months of death)

Date of operation Nov 3 1948

Major findings of operation: marginal enterostomy ulcer & Multiple Adhesions

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Blumbach
Address University Hosp Date signed 4/13/49

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68570

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 112

G68570
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 7 days
(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2005 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country:

3 (a) FULL NAME: Dennish Shugars

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 215-03-2254

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 27, 1878

8. AGE: Years	Months	Days	If less than one day
69	11	17	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Salesman.
11. Industry or business: Gents furnishings

FATHER
12. Name: James Shugars.
13. Birthplace: Maryland

MOTHER
14. Maiden Name: alias McClellan
15. Birthplace: Maryland.

16 (a) Informant: Robert Shugars.
(b) Address: 2005 Homewood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/17/48 (month) (day) (year)
(c) Cemetery or crematory: Hampstead
Location: Carroll Co. Md.

18 (a) Funeral director: Edward C. Tipton
(b) Address: Hampstead Md.

19 (a) (Filed) NOV 15 1948 (b) Huntington Williams, M.D. Registrar

VS 192

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 14 1948, at 8:5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1948, to Nov. 14 1948, and that I last saw him alive on Nov. 14 1948.

Immediate cause of death	Duration
Cardiac failure	2 wks.
Due to: Chronic bronchial asthma.	20 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature: John Robert Shell, M.D.
Address: Mercy Hospital Date signed: Nov 14, 1948

X

G68571

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G68571 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 10-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 E. Madison Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: RICHARD ILES

3 (b) If veteran, name war

3 (c) Social Security Account No. 165-01-4197

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Ida Iles Cornish
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1889

8. AGE: Years	Months	Days	If less than one day
59	5	11	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Watchaman
11. Industry or business Transfer Company

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Ida Iles Cornish
(b) Address 921 E. Madison Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 17-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director ELROY O. WILSON
(b) Address 1007 Brantly ave

19 (a) (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1948, at 7 A.M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 11-15-48

X

Wash 151

Fill in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

668572 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4508 Ashland Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4508 Ashland Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman F. Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha Snyder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 22, 1880

8. AGE: Years	Months	Days	If less than one day
68	2	20	hr. min.

9. Birthplace Washington Co., Md.
(Town, county, and state)
10. Usual Occupation Die grinder,
11. Industry or business

FATHER
12. Name John Snyder
13. Birthplace Maryland

MOTHER
14. Maiden Name Emman Connor
15. Birthplace Maryland

16 (a) Informant Mrs. Bertha Snyder
(b) Address 4508 Ashland Ave.

17 (a) Burial (b) Date thereof 11/16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) 5 1948 (b) Washington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1948 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-2 1948 to Nov 12-1948.
and that I last saw him alive on Nov 12 — 1948.

Immediate cause of death Myocardial insufficiency
Pulmonary Edema
Due to Chronic Nephritis,
Due to Chronic Arteriosclerosis
Other Conditions Acute Cystitis,
(Include pregnancy within 3 months of death)

Duration 5yr.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm F Reese M.D.
M. D.
Address 1564 Mulberry Date signed 11/23/48

VS 150

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G68573
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Siani Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 N Washington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Smith,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Gladys Smith

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Oct 15 1905

8. AGE: Years 41 | Months | Days 28 | If less than one day hr. min.

9. Birthplace Georgia
(Town, county, and state)

10. Usual Occupation Asst Foreman

11. Industry or business Balto Paint & Color Co

FATHER
12. Name Rosa Rinks
13. Birthplace Ga

MOTHER
14. Maiden Name Geo O Smith
15. Birthplace Ga

16 (a) Informant Mrs Gladys Smith
(b) Address 1316 N Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17/48 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Balto

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by Registrar) Washington for Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1948, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 (1948 to 11/13 1948, and that I last saw him alive on 11/13 1948.

Immediate cause of death Hypertensive Hrt. Dis
Arteriosclerotic Hrt. Dis
Cerebral Embolus, Bronchopneumonia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marjorie Oxman M D

Address Sinai Hosp Baltimore Date signed 11/13/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

G68574 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address South Balto Hospital
(c) Hospital or institution: 25 03
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 Cadley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Gertrude Workenfuss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. divorced

6 (b) Name of husband or wife Eduard J Workenfuss

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1895

8. AGE: Years 53 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Montgomery Ryan
13. Birthplace Md

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Wm Weidner
(b) Address 1618 Pentwood Road

17 (a) Burial (b) Date thereof Nov 16/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Paul's Cem
Location Violetsville Balto

18 (a) Funeral director Uhlrich Funeral Home
(b) Address 2008 Orleans St
(Huntington Hillcrest, Md)

19 (a) 5 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Nov. 1948 at 6 30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Edema with
Anasarca
Due to Myocardial Degeneration

Other Conditions Hepatic Cirrhosis due
cardiac failure, chronic
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm F. Kammer M.D.
Medical Examiner.
Date signed 13 Nov. 48

VS 151

93 D

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68575 Welkner

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68575

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St
(c) Hospital or institution: Aged Women's Aged Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Roth Welkner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Charles M. Welkner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1863

8. AGE: Years 85 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Roth
13. Birthplace

MOTHER
14. Maiden Name Margaret Hunderfer
15. Birthplace

16 (a) Informant L. H. Read Supt.
(b) Address 1400 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date of [illegible] 11/16/48 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director William Cook Sons
(b) Address 1217 W Fayette St

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Lexington Mkt

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1948, at 2:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1948 to Nov 12 1948, and that I last saw h[illegible] alive on Nov. 12 1948.

Immediate cause of death Cardiac Failure with Pneumonia

Duration

Due to Myocarditis, Chronic

Due to arteriosclerotic Cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howland Edward Day M. D.
Address 4-E-33rd St - 18 Date signed Nov. 19, 1948

V S 150

X

Please PRINT PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

668576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13a

Registered No. 668576

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 Canvas Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Canvas Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE I. COOPER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Arthur [illegible]
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 14, 1874

8. AGE: Years	Months	Days	If less than one day
73	10	28	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Lease
13. Birthplace Va.

MOTHER
14. Maiden Name Martha MacDonald
15. Birthplace Va

16 (a) Informant Beatrice Cooper
(b) Address 911 Canvas Court

17 (a) Burial [illegible] (b) Date thereof 11/16/48 (month, day) (year)
(c) Cemetery or crematory [illegible]
Location West Virginia

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St

19 (a) NOV 15 1948 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1948 19 . at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 12 1948, and that I last saw h[illegible] alive on Nov 11 1948.

Immediate cause of death: Terminal Pneumonia — Duration

Due to Arterio-Sclerotic Cardio Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work? (Specify) (Yes or No)
(e) Means of injury

23. Signature Paul Luten, M.D.
Address 320 Professional Date signed 11/13/48

X

G68577

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G68577 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2425 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ——
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Longwood St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Gregory (Katherine Gregory)

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1869

8. AGE: Years 78 | Months 10 | Days 29 | If less than one day: ____ hr. ____ min.

9. Birthplace Eatons, W. Va. (Town, county, and state)

10. Usual Occupation Nurse.

11. Industry or business

FATHER 12. Name Thomas Gregory,
13. Birthplace Ireland.

MOTHER 14. Maiden Name Ann Campbell,
15. Birthplace Ireland.

16 (a) Informant Mrs. B. C. Ryan,
(b) Address 1407 Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director L. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14 1948 at 8 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1948 to 11-14 1948 and that I last saw her alive on 11-14 1948

Immediate cause of death: Coma U. Embolism — Duration

Due to Degeneration of Brain

Due to

Other Conditions Acute Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Acute pancreatitis

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? (Specify) While at work?
(e) Means of injury

23. Signature Geo. Richmond M.D.
Address Bon Secours Date signed 11-14-48

V8 153

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68578

1297a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eaton & Madison Sts.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Owings Mills (If outside city or town limits, write RURAL and give town)

(d) Street No. Garrison Field Rd (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME H. Edward Walter

3 (b) If veteran, name war World War # 1

3 (c) Social Security Account No. 216-01-6657

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Married

6 (b) Name of husband or wife Grace Walter

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1/20/1894

8. AGE: Years	Months	Days	If less than one day
54	9	13	hr ____ min ____

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Stock clerk

11. Industry or business U. S. Rubber Co.

FATHER

12. Name Harry J. Walter

13. Birthplace Md

MOTHER

14. Maiden Name Emma C. Price

15. Birthplace Md

16 (a) Informant Mrs. Grace Walters,

(b) Address Garrison Road-Owings Mills Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/16/48 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem.

Location Baltimore, Md.

18 (a) Funeral director L. Vernon Lemmon.

(b) Address 4611 Park Heights Ave.,

19 (a) NOV 15 1948 (Date filed by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1948 at 10 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11/9 1948 to 11/13 1948 and that I last saw h alive on 11/13 1948

Immediate cause of death	Duration
Cardio vascular collapse	
Due to Coronary Occlusion	
Due to	
Other Conditions Benign prostatic hypertrophy (include pregnancy within 3 months of death)	

Date of operation 11/7/48

Major findings of operation: Hypertrophied prostate

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ____ at ____ M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Walter J. Bernard M.D.

Address St. Agnes Hosp. Date signed 11/13/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182B

Registered No. 668579

668579 B.C. 46-21707

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 N. Mount Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH M. WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 7, 1948

8. AGE: Years | Months: 1 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Infant

11. Industry or business

FATHER
12. Name: Charles Wilson
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Doris Furguson
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Doris Wilson
(b) Address: 209 N. Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral Director: Joseph A. Lively
(b) Address: 646 W Baltimore St.

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1948 at 9:10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Mechanical suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-14-48 at ? A. M.
(b) Where did injury occur? 209 N. Mount St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home (While at work) no
(d) Means of injury Overlay of parents (bed)

23. Signature Earl L. Kruger M.D. (Medical Examiner)
Date signed 11-15-48

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. 668580

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1091 N. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1091 N. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Melvin McMillian

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Mary McMillian 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 1898

8. AGE: Years 50 | Months 7 | Days | If less than one day hr. min

9. Birthplace Gibson N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Melvin McMillian
13. Birthplace Gibson N.C.

MOTHER 14. Maiden Name Mary ?
15. Birthplace Gibson N.C.

16 (a) Informant Mary McMillian.
(b) Address 1091 N. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 16, 1948. (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Gilmor St

19 (a) NOV 15 1948 (Date received by Registrar) Huntington Williams, Mgr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1948 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/ 48 to 11/13/48 and that I last saw him alive on 11/11/48

	Duration
Immediate cause of death: Acute Impaction	1 days
Due to (b) Cerebral Hemorrhage	2 days
Due to (c) Hypertension	Many years
Other Conditions Laborer	9 mo

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. T. H. M.D.
Address 5 W. Preston St. Date signed 11/15/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. 668581

668581

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) [illegible]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 160 S. Collins Ave - (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Florence Dutrow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband late DAVID N DUTROW

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) MAY 11, 1874

8. AGE: Years 74 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business —

FATHER 12. Name H m. Haney - decd

13. Birthplace Va!

MOTHER 14. Maiden Name Anna Sullivan decd

15. Birthplace Tenn.

16 (a) Informant MR. CLARENCE DUTROW

(b) Address 105 S. MORLEY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 17 1948 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location 3801 FREDERICK AVE

18 (a) Funeral director Hans H Wiegand

(b) Address 4100 Edmondson Ave

19 (a) NOV 15 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 14 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1948 to 11/14 1948 and that I last saw her alive on 11/14 1948

Immediate cause of death
Ca head of Pancreas & metastasis —
Due to Biliary obst. —
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 51, Agnes Way Date signed 11-14-48

VS 153

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1647

G68582
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 18
(e) Length of stay in Baltimore (yrs., mos., or days) 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY C. OHM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Henry W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1896

8. AGE: Years	Months	Days	If less than one day
52	8	1 19	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Carr
13. Birthplace Md.

MOTHER
14. Maiden Name Mary ---
15. Birthplace Md.

16 (a) Informant Mr. Henry W. Ohm
(b) Address 3400 Edmondson Ave.

17 (a) Buried (b) Date thereof Nov. 17 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Harry A Welsh
(b) Address 4/6 Edmondson Ave

19 NOV 15 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1948 at 1:50PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage

Due to Incised wound of neck

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 13'48 at Approx. 8 A.M.
(b) Where did injury occur? 3400 Edmondson Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Slashed throat with paring knife

23. Signature Emil Ruzga M.D.
Medical Examiner.
Date signed 11/15/48

VS 151

X

G68583

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68583

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Charles A. Hartman

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-0239

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Wh. Tb	Married

6 (b) Name of husband or wife Mrs. Regina Hartman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 22 (~~1899~~) 1899

8. AGE: Years	Months	Days	If less than one day
49	0	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Frentz Pharmacy

FATHER
12. Name Anthony Hartman
13. Birthplace W. Va.

MOTHER
14. Maiden Name Josephine Barber
15. Birthplace Md

16 (a) Informant Mrs. Charles Hartman
(b) Address 1804 W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16 '48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd

18 (a) Funeral director Harry A. Wilhelm
(b) Address 5400 Belair Rd

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12 1948, at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1948 to 11/12 1948, and that I last saw him alive on 11/12 1948.

Immediate cause of death	Duration
Heart Failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, etc.)
(e) Means of injury

23. Signature William J. Womack M. D.
Address Bon Secours Hosp. Date signed 11/12/48

VS 199

Please write clearly, especially important. Physician: please write the causes of death clearly and legibly.

G68584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. G68584

G68584

Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 935 Homestead St.
(c) Hospital or institution: 4-05
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 935 Homestead St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Walsh

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mollie V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 17th 1886

8. AGE: Years	Months	Days	If less than one day
62	8	28 27	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Confectionary Keeper
11. Industry or business For Self

FATHER
12. Name Timothy Walsh
13. Birthplace Dreland

MOTHER
14. Maiden Name Annie O'Reilly
15. Birthplace Dreland

16 (a) Informant Mrs. Mollie V. Walsh
(b) Address 935 Homestead St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4340 Old Frederick Rd.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.

19 (a) NOV 15 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 15

20. DATE OF DEATH Nov 14th 1948, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10 1948, to 11/14 1948, and that I last saw h alive on 11/13 1948.

Immediate cause of death Cerebral Hemmorhage — Duration 1 mo.
Due to Hypertension
Due to Nephritis
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm J. Traverse
Address 1VV Wsee Date signed 11/15/48

VS 150

68585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. 68585

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital 4-01
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 331 North Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND STIVER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1882

8. AGE: Years 66 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Attendent at race track

11. Industry or business

FATHER
12. Name Joseph Stiver
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Campbell
15. Birthplace Maryland

16 (a) Informant Mrs. H. Stiver
(b) Address 102 N. Monroe St.

17 (a) cremation (Burial, cremation, or removal) (b) Date thereof 11-17-48 (month) (day) (year)
(c) Cemetery or crematory Ladon Park
Location Frederick Rd.

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N. Patterson Park

19 (a) NOV 15 1948 (Registered by registrar) (b) [illegible] Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1948, at 6.00 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull with intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-12-48 at approx. 2.30 P. M.
(b) Where did injury occur? Park Hgts. & Paton Aves.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury knocked to ground during altercation

23. Signature [signature] M.D.
Medical Examiner.
Date signed November 15, 1948

VS 131

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68586

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G68586

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 S. Potomac St.
(c) Hospital or institution: 1-0 r
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 S Potomac St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie S. Dingle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. B. Dingle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Febr 24-1883

8. AGE: Years	Months	Days	If less than one day
65	8	21/20	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name George Lamm
13. Birthplace Baltimore

MOTHER
14. Maiden Name Christine Effling
15. Birthplace Baltimore Md.

16 (a) Informant Francis Dingle
(b) Address Bengies 20 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd.

18 (a) Funeral director Elizabeth Hartle Funeral
(b) Address 115 E. West St.

19 (a) NOV 15 1948 (Date rec'd by registrar) Lemington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1948 at 10:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1948, to Nov 24 1948, and that I last saw her alive on Nov 13 1948.

Immediate cause of death Coronary Occlusion — Duration 2 days

Due to Hypertensive Card-vasc dis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Lill M. D.
Address 2843 St Paul St Date signed Nov 15, 1948

VS 150

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. ... ENTERING INK. Every item of information should be carefully supplied. The

G68587

HEALTH DEPARTMENT—CITY OF BALTIMORE

G68587

SOCIAL SECURITY 219-10-1478 CERTIFICATE OF DEATH 13 1a

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 Sulgrave Ave St., 27 Ward)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

If U. S. Veteran specify WAR ...

2. FULL NAME CHARLES LEWIS IMHOFF 27-15

(a) Residence: No. 1621 Sulgrave Ave St., ... Ward 27

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Thompson Imhoff

6. DATE OF BIRTH (month, day, year) Feb. 4-1887

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	9	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Caretaker

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ...

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME George Imhoff

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Matilda

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Mrs. Emma Imhoff

(Address) 1621 Sulgrave Ave.

18. BURIAL, [illegible]

Place Woodlawn Cemetery Date Nov. 16-1948

19. UNDERTAKER Burgee Funeral Home

(Address) 3631 Falls Road Balto. Md.

20. FILED NOV 15 1948 Huntington Williams M.D. Registrar.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov. 13-1948. 19

22. I HEREBY CERTIFY, That I attended deceased from November 1948 to Nov 13 1948

I last saw him alive on Nov. 13 1948 Death is said to have occurred on the date stated above, at 6.25 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocarditis Chronic	
Nephritis Chronic	
Other contributory causes of importance: Uremic Coma — due to Nephritis Chronic	2da

Was an operation performed? No Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? Usual Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?

If so, specify ...

(Signed) Sherman C. Mantz M. D.

(Address) 260 Manhattan Ave

Nov. 13/48

VS 3

G68588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

G68588

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days

(e) Length of stay in Baltimore (yrs., mos., or days) 9 09

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1503 HOLBROOK ST. (If rural give location)

(e) Citizen of foreign country? NO. (Yes or No) If yes, name country .....

3 (a) FULL NAME WILLIAM JOSEPH SCHMIDT

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	MARRIED.

6 (b) Name of ~~husband~~ or wife ANNE Theresa Schmidt

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) Oct. 23, 1898

8. AGE: Years	Months	Days	If less than one day hr.	min.
50	0	23	.....	.....

9. Birthplace BALTIMORE, MD. (Town, county and state)

10. Usual Occupation CLERK

11. Industry or business G+E Co.

FATHER 12. Name August Schmidt

13. Birthplace Md

MOTHER 14. Maiden Name Hilda

15. Birthplace .....

16 (a) Informant Mrs. A.T. Schmidt

(b) Address 1503 Holbrook St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Bal

18 (a) Funeral director L. J. Luck

(b) Address 5305 Harford Rd.

19 NOV 15 1948 (Date rec'd by Registrar) Huntingtown, Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1948 at 3:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12, 1948 to Nov. 14 1948, and that I last saw him alive on Nov. 14, 1948.

Immediate cause of death Respiratory Failure — Duration .....

Due to Coronary Thrombosis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

of autopsy: .....

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature Frank Behm, Jr. M.D.

Address St. Joseph's Hospital Date signed 11-14-48

VS 150

X

668589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. 668589

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 Aldershot Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE LAUTENBERGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1882

8. AGE: Years	Months	Days	If less than one day
66	9	11 10	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name George Lautenberger
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Elizabeth Ruhland
15. Birthplace Germany

16 (a) Informant G. Frederick Lautenberger
(b) Address 808 Cathedral Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore, Maryland

18 (a) Funeral director HARRY N. ARMACOST
(b) Address 4204 Ridgewood Avenue

19 (a) NOV 15 1948 Date rec'd by registrar (b) Huntington-Mitchell, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1948, at 8:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-12-48 at 8:19 P.M.
(b) Where did injury occur Overbrook Rd. & York Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Earl Ryan M.D.
Medical Examiner
Date signed 11-13-48

VS 181

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

668590 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1238 E. Fort Ave.
(c) Hospital or institution. —— ? H. O.
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) about 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1238 E. Fort Ave. (If rural give location)
(e) Citizen of foreign country? —— (Yes or No)
If yes, name country ——

3 (a) FULL NAME Susie A. Gardner

3 (b) If veteran, name war —— 3 (c) Social Security Account No. ——

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Charles W. Gardner 6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) June 12 1879

8. AGE: Years 69 Months 5 Days 2 If less than one day hr. min.

9. Birthplace Queen Anne's Co., Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business ——

FATHER 12. Name Walter Poe
13. Birthplace Md.

MOTHER 14. Maiden Name Mafelda Hancock
15. Birthplace Md. (Dayton)

16 (a) Informant Mrs. Dorothy E. Zakrzewski
(b) Address 1238 E. Fort Ave., Balto 30 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Tues, Nov 16, 1948 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location B. C. Co., Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 E. Chase St., Balto 30 Md.

19 (a) [illegible] (b) Huntington, W. Va.

NOV 15 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sun, Nov 14 1948, at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1948 to 11/14 1948 and that I last saw her alive on 11/13 1948.

Immediate cause of death	Duration
Arteriosclerotic heart dis.	2 y
Due to Generalized arteriosclerosis.	?
Due to	
Other Conditions Cerebral arterio sclerosis.	

(Include pregnancy within 3 months of death)

Date of operation ——
Major findings of operation: ——
Date of autopsy: ——

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ——
(b) Date of occurrence —— at —— M
(c) Where did injury occur? —— (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? —— While at work? —— (Specify type of place)
(e) Means of injury ——

Signature Julius Loebl M. D.
Address 1800 N. Charles Date signed 11/15/48

Julius Loebl X

G-68591

G68591

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928 S. Conkling St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 S. Conkling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME LEONARD HEINEMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine Heineman

6 (c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Sept. 1, 1885

8. AGE: Years: 63 | Months: 2 | Days: 11 | If less than one day: ..... hr. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Laborer.

11. Industry or business: Baltimore City.

FATHER 12. Name: Rhinehardt Heineman Sr.

FATHER 13. Birthplace: Germany.

MOTHER 14. Maiden Name: Kunigunda Maule

MOTHER 15. Birthplace: Germany.

16 (a) Informant: Catherine Heineman

(b) Address: 928 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)

(c) Cemetery or crematory: Oak Lawn Cem. Location: 7225 Eastern Ave.

18 (a) Funeral director: Leopold L. Zeiler

(b) Address: 901 S. Conkling St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

NOV 15 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 12, 1948, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 12 1948 and that I last saw him alive on Nov 12 1948.

Immediate cause of death: Pulmonary tuberculosis — Acute tuberculous meningitis — Duration: 1 mo. — Nov. 12

Due to:

Due to:

Other Conditions (Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: None

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature: E. J. Heineman Jr.

Address 872 Eastland Date signed 11 15 48 M. D.

68592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

Registered No. 68592

The entries on this certificate should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2912 Sanbenham Circle

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto 25

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2912 Sanbenham Circle

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Elizabeth Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C	Married

6 (b) Name of husband or wife William A. Hall

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) March 5th 1911

8. AGE: Years	Months	Days	If less than one day: hr.	min.
37	8	7		

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Manager Hostess

13. Birthplace Va.

MOTHER

14. Maiden Name Elizabeth H. Wesley

15. Birthplace Md.

16 (a) Informant William A. Hall

(b) Address 2912 Sanbenham Circle

17 (a) Burial (Burial, cremation, or removal)

(b) Date thereof Nov. 17th 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Balto. Co. Md.

18 (a) Funeral director Byron Thomas & Wright

(b) Address 727 Edgewood St

19 (a) NOV 16 1948 (Date received by registrar) (b) Huntington Williamsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12th 1948 at 5:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1948 to Nov 12 1948

and that I last saw h alive on Nov 11 1948

Immediate cause of death Cardiac Failure

Duration

Due to Cardiovascular disease. 3 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify)

(e) Means of injury

23. Signature A. C. Burrell M. D.

Address 721 Edgewood Date signed 11-15-48

VS 150

68593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G68593

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3407 Woodbrook Ave

(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3407 Woodbrook Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mollie Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1879

8. AGE: Years 69 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Morris

13. Birthplace Russia

MOTHER 14. Maiden Name Etta

15. Birthplace Russia

16 (a) Informant Samuel Schwartz

(b) Address 3407 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 210 Eutaw Place

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15-1948 at 4H M

21. I certify that death occurred on the date above stated, that I attended deceased from 1943 to 11-14 1948.

and that I last saw h alive on 11/14 1948

Immediate cause of death Acute Coronary Thrombosis

Duration 12 days

Due to General Coronary atherosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Owen W Brown

Address 230 Eutaw Pl Date signed 11/15/48

VS 150

X

68594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 68594

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FANNIE PIVOWAR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 72 | Months 2 | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Morris Bratman
(b) Address 3816 Dolfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Old Germany Hill Rd.

18 (a) Funeral director Jack Levi Inc
(b) Address 2100 Eutaw Place

19 NOV 16 1948 (Date rec'd by registrar) (b) Thomas for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15 1948, at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-17 1944 to 11-15 1948
and that I last saw h[illegible] alive on 11-15 1948.

Immediate cause of death Coronary Thrombosis

Duration

Due to

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Home Date signed 11-15-48

VS 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. 68595

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 S. Rose St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 S. Rose St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Sierak

3 (b) If veteran, name war

3 (c) Social Security Account No. 215093315

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Phyllis Sierak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day hr.	min.
56				

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name Joseph Sierak
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine Sipniewska
15 Birthplace Poland

16 (a) Informant Phyllis Sierak
(b) Address 706 S. Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral Director Fred W. Ozazewski
(b) Address 1930 Eastern Ave.

NOV 16 1948 (Date rec'd by Registrar) Huntington Williams (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 48 to Nov 14 1948, and that I last saw h[e] alive on Nov 14 1948

Immediate cause of death: Hypostatic Pneumonia — Duration 11/11/48
Due to Carcinoma of prostate — 3/1/48
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at (M)
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Groarke
Address 801 N Kenwood Ave. Date signed 11/15/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

68596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

140C

Registered No. 68596

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2224 Pennsylvania Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city limits, give township or magisterial district and nearest town)
(d) Street No. 2224 Pennsylvania Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAYBELLE NICHOLAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1919

8. AGE: Years 29 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George A. Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Henrietta Jones
15. Birthplace Maryland

16 (a) Informant Mr. Robert Micholas
(b) Address 2224 Penna. Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location A. A. Co., , Maryland

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle Street

19 NOV 16 1948 (a) Date rec'd by Registrar (b) Printing for Williams, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1948, at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute generalized peritonitis due to infected abortion --- self induced

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil V. Reyer M.D.
Medical Examiner.
Date signed 11-15-48

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G68597

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3525 Keswick Road
(c) Hospital or institution: 13-06

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3525 Keswick Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Virginia Slimmer.

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widow.

6 (b) Name of husband or wife Thomas J. Slimmer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10, 1865

8. AGE: Years	Months	Days	If less than one day
83	–	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business

FATHER
12. Name Jas. H. Engle
13. Birthplace New Jersey.

MOTHER
14. Maiden Name Sarah E. Grady.
15. Birthplace New Jersey.

16 (a) Informant Jay F. Slimmer.
(b) Address 2827 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Road.

18 (a) Funeral director Chester C. Longmire
(b) Address 3438 Poland Ave.

19 NOV 16 1948 (Date rec'd by registrar) (Signature) Chester C. Longmire

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1948 at 1 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15, 1948 to Nov. 13 1948 and that I last saw her alive on Nov. 13 1948.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerotic C.V. Dis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund F. Hammon M. D.
Address 4027 Falls Rd Date signed 11/15/48

VS 150

X

68598

Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 68598

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1435 Boyle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1435 Boyle St.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME MARY VOGEL

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	None	Female	White	Widow

6 (b) Name of husband or wife Adam
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 15, 1863

8. AGE: Years	Months	Days	If less than one day
85	5	28	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Pipka
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline (Unknown)
15. Birthplace Germany

16 (a) Informant Catherine Vogel
(b) Address 1435 Boyle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A. County, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) 11/16/48 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

48

VS 159

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1948 19 , at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 11-13 1948
and that I last saw h alive on 11-13-48 19

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions	

CERTIFICATION APPROVED BY
J. Thurlington Williams, M.D.
CHIEF OR ASST. MEDICAL EXAMINER

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Denis J. McGrath, M.D.
Address 1E. Randall St. Date signed 11/15/48

G68599

BALTIMORE CITY HEALTH DEPARTMENT G68599 Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Eutaw Place & Wilson St.

(b) Street address Marlborough Apts.

(c) Hospital or institution: 14 a1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Marlborough Apts. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** SOLOMON KATTEN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Fannie Katten

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1879.

8. AGE:	Years	Months	Days	If less than one day
69	68	9	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Clothing Salesman.

11. Industry or business The Hub.

FATHER 12. Name Selig Katten,

13. Birthplace Germany.

MOTHER 14. Maiden Name Sarah ?

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Fannie Katten,

(b) Address Marlborough Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48. (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew

Location Baltimore, Md.

18 (a) Funeral director Abrid Sonchkin & Son

(b) Address 1902 Eutaw Place.

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15th. 1948 at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15/1936 to 11/15/1948 and that I last saw h[illegible] alive on 11/15/1948.

Immediate cause of death Coronary Occlusion — Duration Several hours.

Due to

Due to

Other Conditions Coronary Sclerosis — Duration About 5 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Theodore H. Morrison M. D.

Address 11 E. Chase St. Date signed 11/16/48

VS 150

668600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668600 Registered No. 1212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 Woodbourne ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Woodbourne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Muhly

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-05-0954

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Rose M. Beckmann

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Apr. 12 1876

8. AGE: Years 72 | Months 7 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Retired

FATHER
12. Name Christian Muhly
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Bowers
15. Birthplace Md

16 (a) Informant Mrs. William H. Muhly
(b) Address 905 Woodbourne ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17 1948 (month) (day) (year)
(c) Cemetery or crematory St Pauls Evangelical Lutheran
Location Violetville, Balto. Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address 4905 York Rd. Huntington (Huntingdon) Williams, Md

19 (a) NOV 16 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/15/48 19 ... at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/6/1943 19 ... to 11/15/ 19 48, and that I last saw him alive on 11/14/ 19 48.

Immediate cause of death: Uraemia — Duration: 3 days

Due to: Generalized arterio-sclerosis. Chronic nephritis. — ? yrs.

Due to:

Other Conditions: Prostatic hypertrophy benign. Asthma. — ? yrs.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin B Garrett M. D.
Address 11 E. Chase St. City Date signed 11/15/48

VS 150

Physicians: please write the causes of death clearly and legibly. Use no abbreviations or symbols. Do not use ditto marks.

GC8601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

GC8601 Registered No. 82a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 430 N ROSE ST.
(c) Hospital or institution: 6 W

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 430 N ROSE ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT W. ESLER.

3 (b) If veteran, name war: No

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife LOUISE M

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) DEC. 6 - 1900

8. AGE: Years	Months	Days	If less than one day: hr.	min.
47	11	8		

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation

11. Industry or business RETIRED

FATHER
12. Name JOHN ESLER
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name CECILIA HAMIL
15. Birthplace BALTIMORE

16 (a) Informant LOUISE M. ESLER.
(b) Address 430 N ROSE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 17 1948 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location 4300 BELAIR RD

18 (a) Funeral director DIPPEL BROTHERS
(b) Address 1800 E LOMBARD ST.

19 (a) NOV 20 1948 (Date rec'd by registrar) Interment for Williams (registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 14 1948, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 1948 to 11-14-1948, and that I last saw him alive on 11-13-1948.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	3 DAYS
Due to HYPERTENSION	6 YRS
Due to	
Other Conditions PREVIOUS CEREBRAL HEMORRHAGE WITH PARALYSIS (Include pregnancy within 3 months of death)	6 YRS.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature Benj. B. Mosby M.D. M. D.

Address 448 N. Eutaw Ave Date signed 11-15-48

668602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 668604

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 310 Forrest St

(c) Hospital or institution: Good Samaritan Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 D

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto City (If outside city or town limits, write RURAL and give town)

(d) Street No. 310 Forrest St (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** ~~Hester Ball~~ Annie Darby (Williams)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 1882

8. AGE: Years: 66 Months: Days: If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER 12. Name: unknown

13. Birthplace: unknown

MOTHER 14. Maiden Name: unknown

15. Birthplace: unknown

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto City

18 (a) Funeral director Wm J. Jackson

(b) Address 846 Penna Ave

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14/48 19 at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1948 to 11/14/48 19 and that I last saw h alive on 11/14/48

Immediate cause of death: Chronic Myocarditis — Duration

Due to Arteriosclerosis

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm Thomas M. D.

Address 702 S Edmondson Date signed 11/15/48

VS 153

668603 BALTIMORE CITY HEALTH DEPARTMENT 668603 Registered No.

CERTIFICATE OF DEATH 128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 735 Price St
(c) Hospital or institution:
17 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 735 Price St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rebecca Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	married

6 (b) Name of husband or wife Charles Thomas.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) December 26, 1902

8. AGE: Years	Months	Days	If less than one day hr.	min.
45	11 10	1st		

9. Birthplace New Castle, Delaware (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Howard.
13. Birthplace New Castle Del.

MOTHER
14. Maiden Name Sarah Waters.
15. Birthplace New Castle Del.

16 (a) Informant Dorothy Sams.
(b) Address 644 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs Katie Williams
(b) Address 322 N Schroeder St

19 (a) NOV 16 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH hour 13 1948 at 8, ½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1948 to Nov. 3 1948 and that I last saw h alive on Nov 3 1948.

Immediate cause of death	Duration
Pul. tuberculosis	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury
23. Signature W H Watts M. D.
Address 513 Arlington Date signed 11, 16, 48

VS 150

Any erasure, alteration or illegible entry will void this certificate. Please write the cause of death clearly and legibly.

68604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 68604

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp 1607
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) **FULL NAME** John C. Marshall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3/17 1881

8. AGE: Years 67 | Months 7 | Days 30 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Balto. Transit

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Records - Mercy Hosp
(b) Address Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (year)
(c) Cemetery or crematory Olivet
Location St. Michaels, Md

18 (a) Funeral director Norman L. Marshall
(b) Address St. Michaels, Md

19 NOV 16 1948 (Date received by registrar) (Signature of registrar) Lorraine Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16 1948, at 2 35/P M

21. I certify that death occurred on the date above stated; that I attended deceased from N-8 1948 to 11-16 1948, and that I last saw h s alive on 11-16 1948.

Immediate cause of death: Myocardial failure — Duration: 8 days

Due to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Ben Powell, Jr. M. D.
Address Mercy Hosp Date signed 11-16-48

VS 130

G68605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G68605

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 McCulloh St
(c) Hospital or institution: 11 04
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 McCulloh St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES E. BRISTOL

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4/23/1926

8. AGE: Years 22 | Months 6 | Days 20 | If less than one day hr. min. 19

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Huckster

11. Industry or business Arab Business

FATHER
12. Name James H. Edwards
13. Birthplace N.C.

MOTHER
14. Maiden Name Magaret Michael
15. Birthplace N.C.

16 (a) Informant Margaret Bristol (M)
(b) Address 917 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A.County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 NOV 16 1948 (Date rec'd by Registrar) (b) Cunningham-Williams Co

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12th 1948 at 1:A M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-5 1948 to 11-12 1948 and that I last saw him alive on 11 11 1948

Immediate cause of death: Broncho-Pneumonia — Duration: 7 Days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 554 Dolphin St Date signed 11-15-48

VS 150

668606

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

Registered No. 668606

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 2 / c 1
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Abt. 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 925 S. Fremont Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL HERMAN (MENKE) MEINKE

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Cordelia Meinke

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 25, 1881

8. AGE Years 67 | Months 0 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Cleveland, Ohio (Town, county, and state)

10. Usual Occupation Salvation Army

11. Industry or business

FATHER
12. Name Herman Meinke
13. Birthplace Germany

MOTHER
14. Maiden Name ? Ellger
15. Birthplace Germany

16 (a) Informant Records Salvation Army
(b) Address 925 S. Fremont Street

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11-18-48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Maryland

18 (a) Funeral director STEWART MOWEN CO.
(b) Address 108 W. North Avenue

19 NOV 16 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1948, at 7:30 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner

Date signed 11-15-48

VS 181

G68607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68607

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) less than 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Miss. (b) County
(c) City or town Lewis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 437 Front St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM ARCHIE STARVIS

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex M

5. Color or race col

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1895

8. AGE: Years 7 53 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Fisherman

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Adelaide Starvis
15. Birthplace ?

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location W. Baltimore

18 (a) Funeral director A. Polkanis
(b) Address 918-North Ave.

19 NOV 16 1948 (Date rec'd by registrar) Livingston Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1948, at 11:12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1948 to Nov. 11 1948, and that I last saw him alive on Nov. 11 1948.

Immediate cause of death	Duration
1- Nephrosclerosis with uremia	Unknown
2- Cardiac hypertrophy	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon, M. D.
Address Clinical Director Date signed 11/12/48

V S 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

G68608

AB-122697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

G68608

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 13-08

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1432 Millrace Road (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married-Separated

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 25- 1902

8. AGE: Years	Months	Days	If less than one day
45	11	20	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name Walter Butler

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden Name Lulu Rider

MOTHER 15. Birthplace Virginia

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Manga

Location Hanover.

18 (a) Funeral director Paul C. Schwaner & Son.

(b) Address 2116-12 Chestnut Ave.

19 (a) Nov 16 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15- 1948, at 8.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4- 1948, to 11-15- 1948, and that I last saw him alive on 11-15- 1948.

Immediate cause of death: Uremia.

Due to chronic glomerulo nephritis.

Duration 4 wks. ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William H. Vinden Jr. M.D.

Address Balto City Hosp Date signed 15 Nov 48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G68609

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 1307
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 Chestnut Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA SUSAN BUTCHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles W. Butcher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1873

8. AGE: Years	Months	Days	If less than one day
75	2	9	hr. min.

9. Birthplace Tawneytown, Carroll Co., Maryland
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Stanfield Fisher
13. Birthplace Carroll, Co., Md.

MOTHER
14. Maiden Name Sarah Rowe
15. Birthplace Carroll Co., Md.

16 (a) Informant Helen Williams (Daughter)
(b) Address 3712 Chestnut Avenue

17 (a) Burial (b) Date thereof 11-17-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laudon Park
Location Frederick Road

18 (a) Funeral director PAUL E. CHENOWITH, Jr.
(b) Address 3615-17 Chestnut Avenue

19 (a) NOV 16 1948 (b) Huntington Williamson, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1948, at 9 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A. S. C. V. D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl R. Royer M.D.
Medical Examiner
Date signed 11-15-48

VS 191

68610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 68610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 7-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 Roland Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard B Ball

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-7147

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1901

8. AGE: Years 47 | Months 10 | Days 4 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Oiler

11. Industry or business Wm. E. Hooper

FATHER
12. Name John L. Ball
13. Birthplace ? Md.

MOTHER
14. Maiden Name Alice M. Ball
15. Birthplace ? Md.

16 (a) Informant: Carlton L. Hagner
(b) Address 1133 Roland Hgts. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16, 1948 (month) (day) (year)
(c) Cemetery or crematory St Mary's.
Location Hampden

18 (a) Funeral director Paul C. Schumacher
(b) Address [redacted] Chestnut Ave.

19 (a) NOV [redacted] (b) Huntington Williams M.D. Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13th 1948, at 6 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy & Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work
(d) Means of injury

23. Signature William J. Holbrook M.D. Medical Examiner.

Date signed Nov 13, 1948

VS 151

X

668611

Dr. Sunday
201 E. 33rd St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68611

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2017 Sinclair Lane
(c) Hospital or institution: 8 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2017 Sinclair Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry J. Klein, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Alice T. Klein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3. 1888

8. AGE: Years	Months	Days	If less than one day
60	10	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Engineer, B. & O. R.R.
11. Industry or business

FATHER
12. Name George Klein
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Eckmeyer
15 Birthplace Md.

16 (a) Informant Mrs. Alice T. Klein
(b) Address 2017 Sinclair Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) [illegible] for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1948, at 12.05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from MAY- 3 1946 to NOV- 15 1948 and that I last saw him alive on NOV. 15 1948

Immediate cause of death	Duration
ACUTE PULMONARY EDEMA	3 HOURS
Due to ARTERIO SCLEROTIC HEART DISEASE	3 YEARS.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place (Specify which place) While at work?
(e) Nature of injury

23. Signature Stuart D. Sunday M.D.
Address 201 E. 33rd St. Date signed 11/16/48

VS 150

68612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55a

Registered No. 68612

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2124 N. Charles St.

(c) Hospital or institution: Doctors Hosp. 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1711 Orlando Road (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Carroll Hall - -

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M -	W	d.

6 (b) Name of husband or wife Florence I Hall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-20-1887

8. AGE: Years 61 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace St. Mary Co, Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Wm. T. Hall

13. Birthplace Md

MOTHER 14. Maiden Name Mary S. Tippett

15. Birthplace Md

16 (a) Informant Mrs. Ethel Hellwig

(b) Address 3101 Du Bois Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)

(c) Cemetery or crematory Moreland Park

Location Balto

18 (a) Funeral director L. J. Luck

(b) Address 5205 Radford Rd

19 (a) (Date rec'd by registrar) (b) Thurlow Weems Lewis, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15- 1948, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948, to Nov 15 1948, and that I last saw h alive on 11-15 1948.

Immediate cause of death: Metastatic Carcinoma of Liver & Stomach — Duration 4 mos.

Due to Primary Ca Supra Renal

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature Michael Lunsford M.D.

Address 5202 Belair Rd Date signed 11-15-48

VS 150

Spec.—B 24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

668613 668613

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Kenesaw Nursing Home

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2601 Roslyn Avenue ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Victoria Tilghman

(Residence in Baltimore: No. 2601 Roslyn Avenue St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	widowed

6-DATE OF BIRTH. July 7, 1866 (Month) (Day) (Year)

7-AGE. 82 yrs. 4 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Maryland

PARENTS.

10-NAME OF FATHER. Samuel Norman

11-BIRTHPLACE OF FATHER (State or Country). England

12-MAIDEN NAME OF MOTHER Susannah Pindell

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore, Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Miss Ada R. Bierbower

(Address). Blackstone, Va.

15- NOV 16 1948 Huntington-Williamsville, Md.

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. November 14, 1948 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 16 1948, to November 14 1948, that I saw h[er] alive on November 14 1948, and that death occurred, on the date stated above, at 8:55 p m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. O. Bellman M. D.

Nov 14, 1948 (Address) 60 Baltimore Ave Towson, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cemetery, Balto. DATE OF BURIAL. Nov. 16, 48

20-UNDERTAKER John O. Mitchell & Sons, Inc. ADDRESS 1900 Eutaw Pl.

per Madison B. Mitchell

G68614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. G68614

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 1626 Holbrook Street
(c) Hospital or institution: 9 cy
(d) Length of stay in hospital or inst. (yrs., mos., or days): None
(e) Length of stay in Baltimore (yrs., mos., or days): 21 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County: City
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1626 Holbrook Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) **FULL NAME**: John F. Beck

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: 215-16-0345

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Margie A. Hooper
6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Dec. 14th., 1898

8. AGE: Years	Months	Days	If less than one day
49	11	0	######## min.

9. Birthplace: Baltimore County (Town, county, and state)
10. Usual Occupation: Guard
11. Industry or business: Detective Agencies

FATHER
12. Name: Michael J. Beck
13. Birthplace: Baltimore County, Md.

MOTHER
14. Maiden Name: Ada V. Bunch
15. Birthplace: Baltimore County, Md.

16 (a) Informant: Mrs. Margie A. Beck (Wife)
(b) Address: 1626 Holbrook Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/17/48 (month) (day) (year)
(c) Cemetery or crematory: Fork Christian Church Cem.
Location: Fork, Balto. Co. Maryland

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14th 1948, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Nov. 14 1948, and that I last saw him alive on Nov. 14 1948.

Immediate cause of death: Heart Failure — Duration: 2 days
Due to: Myocardial Insufficiency — 4 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Loy M. Zimmerman
Address: 2050 Harford Rd. Date signed: Nov. 15, 1948
M. D.

Loy M. Zimmerman

V S 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 68615

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 wk

(e) Length of stay in Baltimore (yrs., mos., or days): ?

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 4800 Wrenwood Ave. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country:

3 (a) FULL NAME: ERNEST JOSEPH SCHULTZ

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.: yes- ?

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hilda Schultz

6 (c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Nov. 22, 1894

8. AGE: Years: 53 | Months: 11 | Days: 24 | If less than one day: hr. min.

9. Birthplace: So. Dakota (Town, county, and state)

10. Usual Occupation: Storekeeper gauger

11. Industry or business:

FATHER

12. Name: ?

13. Birthplace:

MOTHER

14. Maiden Name: ?

15. Birthplace:

16 (a) Informant: Records

(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-18-48 (month) (day) (year)

(c) Cemetery or crematory: Balto. National

Location: Frederick Rd

18 (a) Funeral director: John A. Moran

(b) Address: 3006 E. Balto St.

19 (a) NOV 16 1948 (Date received by registrar) Huntington for Williams, Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 15 1948 at 1:10PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1948 to Nov. 15 1948. and that I last saw him alive on Nov. 15 1948.

Immediate cause of death: Carcinoma of stomach with perforation and peritonitis

Duration: unkn

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: David D. LeGrand 5:35PM

David D. LeGrand M. D.

Address: US Marine Hospital Date signed: 11/15/

VS 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G68616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1202

Registered No. G68616

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert

(c) Hospital or institution: Union Memorial Hosp. 9-01

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days

(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 622 Wyndhurst Ave. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Thomas Bailey Swanson

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1930

8. AGE: Years	Months	Days	If less than one day: hr.	min
18	3	26		

9. Birthplace Balt., Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER — 12. Name Hartwig A. Swanson

13. Birthplace Sweden

MOTHER — 14. Maiden Name Edythe Styles

15. Birthplace Balt., Md.

16 (a) Informant Parents

(b) Address 622 Wyndhurst Ave., Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Rd

18 (a) Funeral director John R. Moran

(b) Address 3000 E. Balto St.

19 (a) (Date received by registrar) Nov 16 1948 Registrar [illegible]

20. DATE OF DEATH Nov 14, 1948 at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22, 1948 to Nov. 14, 1948 and that I last saw h in alive on Nov. 14, 1948

Immediate cause of death Toxemia — Duration 5 hrs.

Due to Ulcerative colitis, acute — Duration 5 wks.

Due to

Other Conditions G.I. hemorrhage

(Include pregnancy within 3 months of death)

Date of operation 11-9-48

Major findings of operation: Ulcerative colitis

of autopsy: Ulcerative colitis + sigmoid G.I. hemorrhage

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature M. F. Coyne M.D.

Address Union Memorial Hosp. Date signed 11-14-48

VS 150

G68617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G68617 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Approx. 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city limits, write RURAL and give town)
(d) Street No. 34 Melrose Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM J. PADGETT, JR.

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-24-5834

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr	min
21				

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business Service Station

FATHER 12. Name Wm. J. Padget, Sr.
13. Birthplace Maryland

MOTHER 14. Maiden Name Martha Reynolds
15. Birthplace Maryland

16 (a) Informant Mr. J. Padgett, Sr.
(b) Address 34 Melrose Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-48 (month, day, year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John R. Moran
(b) Address 3040 E. Balto. St.

19 (a) Nov 16 1948 (Date) rec'd by registrar (b) Signature of Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1948 at 6:55 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull with intracranial hemorrhage

Due to

Other Conditions (Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-12-48 at 11:35 P. M.
(b) Where did injury occur? Joppa Road, 400' east of Black & Decker Entrance - Balto. Co.
(c) Did injury occur at home, on farm, industrial place, or in public place? Public (What) No
(d) Means of injury Auto. & Auto. Collision

23. Signature Earl L. Rogers M.D. Medical Examiner
Date signed 11-15-48

G68618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G68618

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6042 Yorkshire Drive
(c) Hospital or institution: 27-08

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6042 Yorkshire Dr (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Cecelia Parsons

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Marion S. Parsons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1873

8. AGE: Years 75 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Morgreth
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothy Maache
15. Birthplace Germany

16 (a) Informant Mrs Marie Lorgen
(b) Address 6042 Yorkshire Dr

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3060 E. Baltimore St.

19 (a) NOV 16 1948 (Date received by registrar) (b) Signature for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1948 at 2:14 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Nov 15 1948, and that I last saw her alive on Nov 15 1948.

Immediate cause of death Lobar Pneumonia (TERMINAL) — Duration 2 days

Due to Arteriosclerotic Cardiovascular Disease — Duration 15 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frederick V. D. Wood M. D.
Address 513 E. 39th St Date signed Nov 16

VS 100

Accuracy is especially important. Physicians: please write the causes of death clearly and legibly. The

68619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68619

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 243 Spring Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and name town)
(d) Street No. 243 Spring Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME King Quinn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mattie Quinn

6 (c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): Dec. 25-1880

8. AGE: Years: 67 | Months: 10 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Greenville S. C.
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Bob. Quinn
13. Birthplace: Greenville S.C.

MOTHER
14. Maiden Name: Julia ?
15. Birthplace: Greenville S.C.

16 (a) Informant: Mattie Quinn
(b) Address: 243 Spring Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 17-48
(month) (day) (year)
(c) Cemetery or crematory: Mt. Calvery Cem
Location: Brooklyn Md

18 (a) Funeral director: Elroy O. Wilson
(b) Address: 1000 Bentley ave

19 (a) NOV 16 1948 (b) Remington Pikesville, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 15 1948, at 3 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11-12 1948 to 11-15 1948, and that I last saw him alive on Nov 15 1948.

Immediate cause of death: Arteriosclerotic heart disease

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Duration: unknown

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: G. C. Burrell M. D.
Address: 1V1 Argonne Date signed: 11-15-48

VS 150

X

G68620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G68620

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave.
(c) Hospital or institution: Home for the Aged of the Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 15
(e) Length of stay in Baltimore (yrs., mos., or days) 7

7. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VILLA SAUNDERS SHAW

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Eben S. D. Shaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1864

8. AGE: Years	Months	Days	If less than one day
84	3	15	hr. min.

9. Birthplace Nova Scotia, Canada (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William Saunders
13. Birthplace Nova Scotia, Canada

MOTHER
14. Maiden Name Teuruah Patten
15. Birthplace Nova Scotia, Canada

16 (a) Informant Miss Miriam O. Coates, Supt.
(b) Address Home for the Aged of the Meth. Ch. 2211 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948 at 2:40a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 15 1948 and that I last saw h=A alive on Nov 14 1948.

Immediate cause of death	Duration
Coronary thrombosis	4 hours
Due to Arterio Sclerosis	20 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur F Lanier M D.
Address 800 N 32nd Date signed 11-15-48

VS 130

68621

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

68621 Registered No. 8 2a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Rockdale (If outside city or town limits, write RURAL and give town)
(d) Street No. Mayfield Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. William J. Goode

3 (b) If veteran, name war –

3 (c) Social Security Account No. 212-10-2956

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Marguerite Goode

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 10, 1907

8. AGE: Years 41 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace N. Y. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business WBAL

FATHER 12. Name Wm. B. Goode
13. Birthplace Va.

MOTHER 14. Maiden Name Grace Strong
15. Birthplace N. Y.

16 (a) Informant Mrs. Marguerite Goode
(b) Address Mayfield Ave., Rockdale, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1948, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1948 to Nov 15 1948, and that I last saw him alive on Nov 15 1948

Immediate cause of death: Intracranial Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Benson MD
Address 1401 Hoyt Date signed 11/15/48 (M/D)

John F. Benson

VS 150

G68622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G68622

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4407 Springdale Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28-87

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4407 Springdale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN A. DUVALL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widower

6 (b) Name of husband or wife Edith W. Duvall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 17, 1876

8. AGE: Years	Months	Days	If less than one day
72	7	28	hr. min.

9. Birthplace Croome, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Wm. E. Duvall
13. Birthplace Croome, Md.

MOTHER
14. Maiden Name Mariah Bourne
15. Birthplace Md.

16 (a) Informant Miss Ellen N. Duvall
(b) Address 4407 Springdale Ave.

17 (a) Burial (b) Date thereof 11/17/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Thomas Cem.
Location Croome, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto, Md. for Williams, Md.

19 (a) NOV 16 1948 (b) 6
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Nov 15 1948.
and that I last saw alive on Nov 15 1948

Immediate cause of death	Duration
Coronary Occlusion	1 hr.
Due to Generalized Arteriosclerosis	6 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos J Robertt M. D.
Address 4509 Liberty Heights Date signed

VS 150

G68623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G68623 Registered No.

Please fill the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave
(c) Hospital or institution: Edgewood Nursing Home 2J-12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Bellona Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY B. BOWEN

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Apr. 17, 1862

8. AGE: Years	Months	Days	If less than one day
86	6	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Pullman Conductor, retired
11. Industry or business

FATHER
12. Name George W. Bowen
13. Birthplace Baltimore

MOTHER
14. Maiden Name Charlotte ?
15. Birthplace Baltimore

16 (a) Informant Mrs. Fonsia Weller
(b) Address 2107 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 16 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948 at 7:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1948. to Nov 15 1948. and that I last saw h in alive on Nov. 13 1948.

Immediate cause of death Myocarditis — Duration years

Due to Arterio-Sclerosis generalized — years.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry M. Hermann M. D.
Address 702 E. Preston St. Date signed 11/16/48

VS 130

G68624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G68624

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2904 Wyman Pkwy.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 17

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Wyman Pkwy.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY MARTYN WHITE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	212-16-5152

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna Roberta White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1886

8. AGE: Years	Months	Days	If less than one day
61	11	24	hr. min.

9. Birthplace Lexington, Va.
(Town, county, and state)
10. Usual Occupation President
11. Industry or business North American Oil Co.

FATHER
12. Name Thomas Spottswood White
13. Birthplace Lexington, Va.

MOTHER
14. Maiden Name Sarah Ellen Cameron
15. Birthplace Lexington, Ky.

16 (a) Informant Mrs. Anna R. White
(b) Address 2904 Wyman Parkway

17 (a) Burial (b) Date thereof 11/17/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 16 1948 (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948, at 2:15 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from June 15 1948 to Nov. 15 1948 and that I last saw h/ alive on Nov. 15 1948.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to arteriosclerotic Heart Disease	
Due to	
Other Conditions generalized arteriosclerosis.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford N. Kirkpatrick, Jr. M.D.
Address 6 E. Eager Street Date signed 11-16-48

VS 150

Medical Examiner's Case

Released to Hospital

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30)

Registered No. G68625

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1126 Lombard St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Lawrence

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-5-76

8. AGE: Years 71 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Trinidad (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Walter Lawrence

FATHER 13. Birthplace Trinidad

MOTHER 14. Maiden Name Elma McGuire

MOTHER 15. Birthplace Trinidad

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School NOV 10 1948 Commissioner of Health

18 (a) Funeral director

(b) Address

19 NOV 9 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1948 at 1-03 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/3 1948 to 11/3 1948 and that I last saw h alive on 19

Immediate cause of death Shock, hypoglycemia pulmonary edema smoke poisoning — Duration

Due to

Due to

Other Conditions H AS CVD Syphilis & Acute Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy? No about.

Underline the cause to which death should be charged statistically.

22. If death was due to external causes (violence) fill in the following: CERTIFICATION APPROVED BY CHIEF OR ASST. MEDICAL EXAMINER

(a) Accident, suicide, or homicide

(b) Date of occurrence Howard J. Madden M.D.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm Wilkins

Address J H Hosp Date signed 11/9/48

VS 80

66

G68626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G68626

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2615 N. Hilton St.
(c) Hospital or institution:

15-11

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIAN Stewart WRIGHT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Howard O. Wright
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1888

8. AGE: Years	Months	Days	If less than one day
60	6	1	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Henry Stewart
13. Birthplace N. C.

MOTHER
14. Maiden Name Caroline
15. Birthplace N. C.

16 (a) Informant Mr. Howard O. Wright
(b) Address 2615 N. Hilton St.

17 (a) Burial (Entombment) (b) Date thereof 11/18/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 NOV 16 1948 Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Dawn, M.D.
Medical Examiner.
Date signed

68627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. 68627

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 E. Lanvale St.
(c) Hospital or institution:

9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 E. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES G. BARE, JR.

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Frances L.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1903

8. AGE: Years	Months	Days	If less than one day: hr.	min.
45	2	16		

9. Birthplace: Augusta Co., Va. (Town, county, and state)

10. Usual Occupation: Meat Cutter

11. Industry or business: State Meat Market

FATHER
12. Name: James G. Bare
13. Birthplace: Va

MOTHER
14. Maiden Name: Lydia Kelly
15. Birthplace: Va

16 (c) Informant: Mrs. Frances L. Bare
(b) Address: 1006 E. Lanvale St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/17/48 (month) (day) (year)
(c) Cemetery or crematory: Thornrose
Location: Staunton, Va.

18 (a) Funeral director: William Cook, Inc
(b) Address: 1217 St. Paul St.

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Huntington & Williams Mortuary Inc Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948 19 ____, at 10:AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1948. to 11-16 1948. and that I last saw him alive on 11-13- 1948.

Immediate cause of death: Malignant Tumor of left kidney

Due to: Metastatic tumor to lungs & Brain

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature: R. L. Frost M. D.

Address: 1233 St Paul st Date signed 11-16-48

VS 150

X

668628

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82a

668628 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 E. Chase St.
(c) Hospital or institution:
10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH F. BURKHARDT, SR

3 (b) If veteran, name war	3 (c) Social Security Account No.
World No 1	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 8, 1893

8. AGE: Years	Months	Days	If less than one day
55	7	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business Self

FATHER
12. Name John Burkhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Valeria Lempka
15 Birthplace Germany

16 (a) Informant Mrs Anna H. Burhardt
(b) Address 1000 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A.County, Md.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948 19 , at 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1948 to 11/15 1948 and that I last saw him alive on 11/14/48 19

Immediate cause of death — Duration

Acute Cerebral Hemorrhage

Due to cerebral sclerosis

Due to Hypertension

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify) While at work?
(e) Means of injury

23. Signature A. L. Hornstein
Address 704 E. Biddle St. Date signed 11/16/48 M.D.

VS 13C

68629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123 Registered No. 68629

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd, ashdell

(c) Hospital or institution: Union Mem. Hosp 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 2

(d) Street No. 3333 North Charles (If rural give location)

(e) Citizen of foreign country? If yes, name country O (Yes or No)

3 (a) **FULL NAME** Clairant Parker Cowles Clairant Parker Cowles

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of husband or wife Deceased

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 9, 1872

8. AGE:

Years	Months	Days	If less than one day
76	7	6	hr. min.

9. Birthplace Iowa (Town, county, and state)

10. Usual Occupation professor, teacher, writer

11. Industry or business Retired

FATHER

12. Name Alvin Cowles

13. Birthplace Iowa

MOTHER

14. Maiden Name Viola ?

15. Birthplace Iowa

16 (a) Informant Mrs Janet Cowles

(b) Address 3333 North Charles

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem

Location

18 (a) Funeral director Wm Cook Inc

(b) Address 217 St Paul St

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION 12:03

20. DATE OF DEATH 11-16 1948, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1948, to 11-16 1948, and that I last saw h[illegible] alive on 11-16 1948

Immediate cause of death — Duration

Cerebral embolism

Due to Arteriosclerotic heart disease & Generalized Arteriosclerosis

Due to

Other Conditions Benign prostatic hypertrophy

(Include pregnancy within 3 months of death)

Date of operation 9-27-48

Major findings of operation: Benign prostatic hypertrophy resection 9-27-48

of autopsy: ID Jamieson Williams

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature Mortimer Lee Williams M. D.

Address Union Mem. Hosp. Date signed 11-16-48

VS 150

68680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 68680

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL 11-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) DO A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 Tyson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH BANKIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Unknown

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years: 68 | Months | Days | If less than one day: hr. min

9. Birthplace: Unknown (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

Unknown

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

University Medical School NOV 15 1948
Commissioner of Health

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 31

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1948 at 7:45 PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [x], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 11/6/48

068631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 135a

Registered No. 068631

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 Henneman Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Henneman Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES L. SCHUCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married-separated

6 (b) Name of husband or wife William J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1904

8. AGE: Years	Months	Days	If less than one day
44	4	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Bolek
13. Birthplace Unknown

MOTHER
14. Maiden Name Francis Ulilik
15. Birthplace Unknown

16 (a) Informant William J. Schuch
(b) Address 1120 N. Luzerne Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 11-17-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Schumeka Funeral Home Inc.
(b) Address 2601 E. Madison, St.

19 NOV 17 1948 (Date rec'd by registrar) (Huntington Williams, M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1948, at 1.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Pelvic Peritonitis
Cystitis
Due to Malnutrition

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royston M.D.
(Medical Examiner)
Date signed November 15, 1948

VS 151

6632

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

Registered No. G68632

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5412 TRAMORE RD
(c) Hospital or institution: 27-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5412 TRAMORE RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARGARET E. WALTER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	MARRIED

6 (b) Name of husband or wife IRVIN J. WALTER
6 (c) If alive, give age 91 years

7. Birth date of deceased (mo., day, yr) JAN 14, 1867

8. AGE: Years	Months	Days	If less than one day
81	10	2	hr. min.

9. Birthplace TYASKIN, MD
(Town, county, and state)
10. Usual Occupation AT HOME
11. Industry or business

FATHER
12. Name JOHN W. JONES
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ADELINE PORTER
15. Birthplace MARYLAND

16 (a) Informant MRS ROLAND MARSHALL
(b) Address 5412 TRAMORE RD

17 (a) REMOVAL (b) Date thereof 11/17/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. MARYS P.E
Location TYASKIN MD

18 (a) Funeral director ULLRICH FUNERAL HOME
(b) Address 2004 ORLEANS ST

NOV 17 1948 (b) Huntingtown, Md.
(Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 16 1948 at 7:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from JUNE 1947 to NOV 1948
and that I last saw h[illegible] alive on NOV 12 1948.

Immediate cause of death Duration
Fur advanced acute lobar pneumonia
Due to & senility.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Brennan M. D.
Address 527 Harford Road Date signed 11-16-48

VS 150

X

68633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 68633

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 McElderry St.
(c) Hospital or institution:

7-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 McElderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH WILLIAMS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/12/1900

8. AGE: Years	Months	Days	If less than one day
48	8	2	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name David Williams
13. Birthplace Va.

MOTHER
14. Maiden Name Cora ?
15. Birthplace Va.

16 (a) Informant Mamie Williams
(b) Address 1602 McElderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary / 18/48
Location A.A. County

18 (a) Funeral director Lattie Gross
(b) Address 1408 Ashland ave

19 (a) NOV 17 1948 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1948 at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma, Right Breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, street or public place? While at work?
(d) Means of injury

23. Signature John R. Ness M.D.
(Medical Examiner)
Date signed 11/15/48

VS 151

G68634

AB -124630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1092

Registered No. G68634

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 331 Finch Ct. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John R. Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 10-1945

8. AGE:

Years	Months	Days	If less than one day
3	9	6	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Henry Taylor

13. Birthplace Virginia

MOTHER

14. Maiden Name Annie M. Allan

15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 21-48 (month) (day) (year)

(c) Cemetery or crematory Blandford Cem. Petersburg Va

Location

18 (a) Funeral director Elroy O Wilson

(b) Address 1098 Brantley ave

19 NOV 17 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 19 48 at 11.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16- 19 48 to 11-16 19 48, and that I last saw h im alive on 11-16- 19 48.

Immediate cause of death Pneumonia — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William P. Kean

Address Baltimore City Hospitals Date signed 11-16-48

VS 150

668635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 668635

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 8 days
(e) Length of stay in Baltimore (yrs., mos., or days): 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: NJ (b) County:
(c) City or town: Wildwood (If outside city or town limits, write RURAL and give town)
(d) Street No.: 501 Tacony Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: CHARLES HENRY DWYER

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: 163-07-6863

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 13, 1894

8. AGE: Years: 54 | Months: 6 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Pa. (Town, county, and state)

10. Usual Occupation: Fisherman

11. Industry or business:

FATHER
12. Name: Charles Henry Dwyer
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Julia A Toggweiler
15. Birthplace: Pa.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: 11/17/48 (month) (day) (year)
(c) Cemetery or crematory: Fairview Cem.
Location: Cape May County, N. J.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 NOV 17 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16 1948 at 12:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1948 to Nov. 16 1948 and that I last saw him alive on Nov. 16 1948.

Immediate cause of death: Nephrosclerosis with hypertension and uremia — Duration: Unknown

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Manner of injury:

(b) Signature: C. F. van Ackeren, Medical Director M. D.
Address: Medical Officer in Charge Date signed 11/16/48

VS 180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G688636

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 135 North Exeter Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME: Mabel B. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-6563

4. Sex: female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: James Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19, 1912

8. AGE: Years 36 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual Occupation: Laundress

11. Industry or business

FATHER
12. Name: Charles Butler
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Henrietta ?
15. Birthplace: Virginia

16 (a) Informant: James Holley
(b) Address: 135 N. Exeter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)
(c) Cemetery or crematory: Mt Auburn
Location: Baltimore, Md.

18 (a) Funeral director: Charles R. Law
(b) Address: 802 Madison Ave

19 NOV 17 1948 (Date rec'd by registrar) (b) Huntington Hollins, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1948, at 9.15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Subdural hemorrhage, compressing the brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. (Medical Examiner)
Date signed 11/15/48

G8637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G68637

Registered No. .....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3016 Wylie Ave

(c) Hospital or institution:

27-16

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3016 Wylie Ave (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Sarah Faga Siegel

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Hyman

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 1874

8. AGE: Years 74 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation .....

11. Industry or business House Wife

FATHER

12. Name Joseph Lubowsky

13. Birthplace Russia

MOTHER

14. Maiden Name Gella ?

15. Birthplace Russia

16 (a) Informant Morris Siegel

(b) Address 3016 Wylie Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17, 1948 (month) (day) (year)

(c) Cemetery or crematory Bnai Israel Cemetery

Location Southern Ave

18 (a) Funeral director: Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

19 NOV 17 1948 (Date rec'd by registrar) Huntington Williams M.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1948 to Nov. 17 1948, and that I last saw h[illegible] alive on Nov. 16 1948.

Immediate cause of death: Cerebral hemorrhage — Duration: .....

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature Benjamin Kadri M. D.

Address 2206 Eutaw [illegible] Date signed 11-17-48

VS 150

X

8638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G68638

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12-
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Latrobe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Silas BURRELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-14-1869

8. AGE: Years	Months	Days	If less than one day
78 79	11	-	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Jackson Burrell
13. Birthplace Virginia

MOTHER
14. Maiden Name Irene ?
15. Birthplace Virginia

16 (a) Informant Mrs. Mattie Phillips
(b) Address 1703 Latrobe St.

17 (a) Burial (b) Date thereof 11-17-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. G. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) NOV 17 1948
(Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1948, at 5.10a M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A.S.C.V.D.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Kruger M.D.
Medical Examiner
Date signed November 15, 1948

VS 151

68639 LCH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12B

Registered No. G68639

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 S. Elwood Avenue 16 (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME EDMUND J. ZACHARSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-18-4931

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 7/4/1900

8. AGE: Years	Months	Days	If less than one day
48	4	12	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edmund Zacharski
13. Birthplace Poland

MOTHER
14. Maiden Name Julia Hoppe
15. Birthplace Poland

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-19-48 (month) (day) (year)
(c) Cemetery ~~cemetery~~ HOLY ROSARY
Location BALTIMORE CO, MD

18 (a) Funeral director George A Weber
(b) Address 705 South Arm st

19 NOV 17 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16/48 19 at 5:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27/48 19 to 11/16/48 19 and that I last saw him alive on 11/16/48 19

Immediate cause of death For advanced pulmonary tuberculosis — Duration 6 mo.

Due to

Due to

Other Conditions Chronic alcoholism & vitamin deficiency — Duration years
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret A. Morgan M.D.
Address Balt. City Hospital Date signed 11-16-48

VS 150

68640

AD# 15958

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. 68640

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs.

21

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 765 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Moody

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife. Bertha (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 30- [illegible]886

8. AGE: Years	Months	Days	If less than one day
62	5	12	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Charles ?
13. Birthplace ?

MOTHER
14. Maiden Name Maria ?
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Ct
Location Balt City

18 (a) Funeral director Isaiah T Brown Sr
(b) Address 126 W Montgomery St

19 (a) NOV 1 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11- 1948 at 7.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6- 1936 to 11-11- 1948 and that I last saw him alive on 11-11- 1948.

Immediate cause of death Subarachnoid hemorrhage — Duration 4 days

Due to Arteriosclerotic vascular disease

Due to

Other Conditions Bronchopneumonia RUL. — one week

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Denis Mearine M.D.
Address Balto City Hosp Date signed 11-15-48

VS 150

G68641

GM. 3827

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12a

G68641 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 430 S. Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Kearney

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March -9-1877

8. AGE: Years 71 Months 9 Days 6 If less than one day hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name James Kearney
13. Birthplace Ireland

MOTHER 14. Maiden Name Catherine Lear
15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18-1948 (mo., day) (yr.)
(c) Cemetery or crematory New Cathedral
Location Balto. City

18 (a) Funeral director Pott & B.M. Walker
(b) Address Pott Chuckas &

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11- 15 - 1948 at 7.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10- 20- 1938 to 11- 15 1948. and that I last saw him alive on 11-15 1948

Immediate cause of death: Pneumoconiosis with secondary
Due to Far advanced Pulmonary Tuber-
Due to culosis — Duration: 29 yrs.

Other Conditions Chronic Obliterative Pericarditis
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —

of autopsy: above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address Balto. City Hosp. Date signed 11-20-48

VS 150

X

68642

AB- 124601

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 74a

Registered No. 68642

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Heinerman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife ? Bernard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 25- 1881

8. AGE: Years	Months	Days	If less than one day
67	0	21	hr. min.

9. Birthplace Maryland (Town, County, and state)
10. Usual Occupation ? Saleslady
11. Industry or business Goodwill Industries

FATHER
12. Name James Riley
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Fe
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location

18 (a) Funeral director Wm Cook Inc
(b) Address 217 S Paca St

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Huntington Nolligan, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16- 1948 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15- 1948 to 11-16- 1948, and that I last saw her alive on 11-16- 1948

Immediate cause of death - Lymphatic Leukemia ?

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
MRN
no any large
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. F. Nelson M.D.
Address BCH Date signed 11-16-48

FOR USE OF CORONER OR MEDICAL EXAMINER

VS 150

668643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 1685[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st.
(c) Hospital or institution: Provident Hospital 32
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hour
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Division st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence D Coles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 1910

8. AGE: Years	Months	Days	If less than one day: hr.	min.
38				

9. Birthplace Ga.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name William Coles
13. Birthplace Ga

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Va

16 (a) Informant Sarah Coles
(b) Address 610 E Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17, 48 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Samuel Johnson
(b) Address 1517 Division St

19 (a) Nov 17 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1948, at 1:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 noon 11/12 1948, to 12 M 11/12 1948, and that I last saw him alive on 11-12 1948.

Immediate cause of death: Renal Failure-Uremia — Duration

Due to Hypertensive Cardio-vascular renal disease

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emerson C. Walden, M. D.

Address Provident Hospital Date signed 11-14-48

VS 150

G68644 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G68644
CERTIFICATE OF DEATH 124 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address RAYNOR & DUNDALK Ave.
(c) Hospital or institution: WEST BALTO. GENERAL HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town DUNDALK (If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 LIBERTY PKWY. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME William ARNholter
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife ANNA V. ARNHOLTER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 22, 1904

8. AGE: Years 44 | Months 4 | Days 23 | If less than one day 22 hr. min.

9. Birthplace SOUTH CAROLINA (Town, county, and state)
10. Usual Occupation SUPERVISOR
11. Industry or business BAKERY

FATHER 12. Name GEORGE ARNHOLTER
13. Birthplace SOUTH CAROLINA

MOTHER 14. Maiden Name IDA
15. Birthplace SOUTH CAROLINA

16 (a) Informant ANNA V. ARNHOLTER
(b) Address 2603 LIBERTY PKWY.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 18, 1948 (month) (day) (year)
(c) Cemetery or crematory MARYLAND MEMORIAL
Location TAYLOR AVE, BALTO CO. MD.

18 (a) Funeral director Roland L Fisher
(b) Address 2112 DUNDALK AVE.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 8:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 17 1948 to Nov 17 1948 and that I last saw h[illegible] alive on Nov 14 48.

Immediate cause of death Acute Hemorrhagic pancreatitis. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Acute hemorrhagic pancreatitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature Leonard Lecher M.D.
Address 1061 Baltimore Date signed Nov 17, 1948

VS 150

AB- 123868 668645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45a

Registered No. 668645

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or if not (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 N. Maderia St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Schnader

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband / wife George J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 7- 1883

8. AGE: Years	Months	Days	If less than one day
65	8	9	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Jacob Kattail (D
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Ahesser or Abesser (D
15. Birthplace Germany

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18 1948 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto.
Location E. North Ave Ext

18 (a) Funeral director Lee G. Crook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) Filed by registrar (b) Huntington Williams M.D. Registrar

Nov 17 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16- 1948, at 1.30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10-19- 1948 to 11-16- 1948, and that I last saw h[illegible] alive on 11-16- 1948

Immediate cause of death [illegible] — Duration Hours

Due to [illegible]

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible], M.D.
Address [illegible] Eastern Ave. Date signed [illegible]

VS 150

68646 BALTIMORE CITY HEALTH DEPARTMENT 68646
CERTIFICATE OF DEATH 477
Registered No. 44

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address — Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Always

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pontic Box 731
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Same (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME George V. Kouba, Sr. Kouba

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-6866

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mrs. Elizabeth Kouba
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3 1891

8. AGE: Years 57 | Months 10 | Days 12 | If less than one day hr min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation — mechanic

11. Industry or business Self - employed

FATHER 12. Name Vincent Kouba
13. Birthplace Prague, Czechoslovakia (PRAGUE)

MOTHER 14. Maiden Name — Elizabeth Az
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Kouba
(b) Address 672 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18-48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Beland Rd

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave. Canton

19 (a) Nov. 17-48 (Date rec'd by registrar) (b) John G. Connelly (Registrar)
Huntington Ave Baltimore, Md

NOV 17 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/15 1948 at 5:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/8 1948, to 11/15 1948, and that I last saw h alive on 11/15 1948

Immediate cause of death — Cardiac failure
Cancer stomach
operation

Duration

Due to Infection

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald W. Mintzer M.D.

Address Church Home Date signed 11/16/48

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68647 ✓ 97

Registered No. G68647

G68647

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 Forest St.
(c) Hospital or institution: 10+
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) about 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Forest St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Philip Krasser

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Widowed

6 (b) Name of husband or wife: Mary Kramer nee Gunderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23 1866

8. AGE: Years	Months	Days	If less than one day
81	11	22	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Cabinet Stable work
11. Industry or business Balto City Health Dept.

FATHER
12. Name Jacob Kramer
13. Birthplace Germany

MOTHER
14. Maiden Name Annie Miller
15. Birthplace Germany

16 (a) Informant Mrs J. C. Wagner (Niece)
(b) Address 182 Fairfield St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4430 Belair Rd.

18 (a) Funeral director Edward W. Conklin
(b) Address 924 E. Eager St.

19 (a) 11 1948 (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948 at 3p M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 19 . to 11/13 19 48
and that I last saw h[illegible] alive on 11/13 19 48

Immediate cause of death — Duration

Acute Coronire Dilatation
Due to Ch Sclerosis
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 704 E. Bradford St Date signed 11/16/48

Burial Permit issued by Huntington Williams Registrar

V S 130

668648

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668648

92a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1016 Sterling St.
(c) Hospital or institution:
10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Mone
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 Sterling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Joseph Marshall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3/17/04

8. AGE: Years 44 | Months 7 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Saxe, Virginia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Henry Johnson
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15 Birthplace

16 (a) Informant Joseph Marshall
(b) Address 1016 Sterling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Baltimore, Maryland

18 (a) Funeral director Charles R. La...
(b) Address 802 Madison Ave.

19 (a) Thurlington Williams, M.D. Registrar
(Date received by registrar) NOV 17 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 19 48 at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 19 48 to 11/14 19 48.
and that I last saw h... alive on 11/14 19 48.

Immediate cause of death: Cardiac Failure — Duration: 2 hrs.
Due to: Cerebral Hemmorhage — 3 Yrs.
Due to: Hypertension — 5 Yrs.
Due to: Aortic Insufficiency
Due to: Pulmonary Congest...
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thurlow R. Williams
Address 802 Madison Ave Date signed 11/15/48

X

G68649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G68649

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Montpelier Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES HEIMILLER

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-5655

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Sarah E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1881

8. AGE: Years	Months	Days	If less than one day
66	11	26	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Charles Heimiller
13. Birthplace Maryland

MOTHER
14. Maiden Name Matilda Kerr
15. Birthplace Maryland

16 (a) Informant Mrs. Sarah Heimiller
(b) Address 1625 Montpelier St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-48 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (Date) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1948, at 12.15 P M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.

Date signed November 16, 1948

mp

VS 181

G68650 ✓ G68650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway & Fairmount Ave
(c) Hospital or institution: Church Home & Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3034 Pinewood Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME August Swanson

3 (b) If veteran, name war: no
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	married ~~widowed~~

6 (b) Name of husband or wife Mary L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1872 - May 5

8. AGE: Years	Months	Days	If less than one day
76	6	11	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Charles Swanson
13. Birthplace Sweden

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany

16 (a) Informant Self
(b) Address 3034 Pinewood ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, MD

NOV 17 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1948, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1948 to Nov 16 1948 and that I last saw him alive on Nov 16 1948.

Immediate cause of death Uremia — Duration 3 days

Due to Prostatic hypertrophy

Due to

Other Conditions bilateral hydronephrosis
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard M. Garrett, D
Address Church Home & Hosp Date signed 16 Nov 48

68651

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 68651 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Hanover St. (S) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAURICE E. COLEMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1885

8. AGE: Years 63 | Months 2 | Days 21 | If less than one day: hr. min.

9. Birthplace Cumberland, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Coleman
13. Birthplace New York City

MOTHER
14. Maiden Name Catherine Friel
15. Birthplace New York

16 (a) Informant: Louis Stein, Inc.
(b) Address Cumberland, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)
(c) Cemetery or crematory St. Patricks
Location Cumberland, Md.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

NOV 17 1948 (a) (b) Registrar
(Date received by registrar) Washington Nelligans, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948 at 12:40PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A.S.C.V.D.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Boyer M.D.
Medical Examiner
Date signed 11/17/48

G68652

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12/a

G68652
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 12yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 N. East Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Catherine Mabel Speca

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fe.

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frank Speca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1908

8. AGE: Years 40 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Hwie.

11. Industry or business none

FATHER
12. Name Carl A. Toney
13. Birthplace Dothan W.Va.

MOTHER
14. Maiden Name Winnie F. Thompson
15. Birthplace Plum Orchid W.Va

16 (a) Informant Frank Speca (Husband)
(b) Address 136 N. East Ave

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Nov. 20/48 (month) (day) (year)
(c) Cemetery or crematory Family Plot
Location Dothan W.Va.

18 (a) Funeral director Frank Della Rose
(b) Address 322 S.High St.

19 (a) (Filed by registrar) **(b)** Registrar

NOV 17 1948
Huntington, W.Va.

VS 18)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948, at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8/ 1948 to 11/16/ 1948, and that I last saw her alive on 11/16/ 1948

Immediate cause of death Uremia — **Duration**

Due to Arteriolar Nephrosclerosis

Due to Hypertensive Cardio-Vascular Disease

Other Conditions Congestive Failure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?
(e) Means of injury

23. Signature Guy E. Simms Jr. M.D.
Address 1st Huntington Nat'l Bank **Date signed** 11/19/48

G68653

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G68653
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: GENERAL GERMAN AGED PEOPLES HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. ATHOL AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH SCOTT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: Late STONEWALL J.D. SCOTT

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 15, 1868

8. AGE: Years 80 | Months — | Days 1 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant GENERAL GERMAN HOME
(b) Address 22 S ATHOL AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 18 1948 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 38 & FREDERICK AVE

18 (a) Funeral director Harry H. Wetzler
(b) Address 4101 Edmondson Ave

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Kenneth Williams, M.D. Registrar

MEDICAL CERTIFICATION 3.20

20. DATE OF DEATH NOV. 16 1948 at A. M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 2/48 19 to Nov. 16/ 1948. and that I last saw her alive on Nov. 14/ 1948.

Immediate cause of death	Duration
Broncho-Pneumonia	14 days.
Due to	
Due to	
Other Conditions Unknown	
Arterio-Sclerosis. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(c) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Hecht Lewis M.D.
Address 723 Hamilton Ave Date signed Nov 17 48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G68654

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G68654
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 N. Bolton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isabel L. Bosa

3 (b) If veteran, name war	3 (c) Social Security Account No. 215-05-4900

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-12-04

8. AGE: Years	Months	Days	If less than one day
44	7	3	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Stenographer
11. Industry or business INTERNATIONAL HARVESTER

MOTHER / FATHER
12. Name Geo Geo Bosa
13. Birthplace Md
14. Maiden Name Pauline Straehfe
15. Birthplace New York

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 18 '48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE

18 (a) Funeral director Harry H Wyke
(b) Address 4101 Edmondson Ave

19 (a) NOV 17 1948 (Date rec'd by registrar) (b) Huntington for Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1948, at 2 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1948 to 11/15 1948 and that I last saw her alive on 11/15 1948.

Immediate cause of death: Carcinoma of the Breast with metastases — Duration: 1 yr
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation June 1948
Major findings of operation: Carcinoma left breast
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Handelsman M. D.
Address Johns Hopkins Hosp Date signed Nov 15, 1948

VS 150

G68655

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G68655
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be entirely supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2321 Harlem Ave.
(c) Hospital or institution None
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 83-3-5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2321 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa C. Schange

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George L. Schange

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1865

8. AGE: Years 83 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Conrad Neidhardt

13. Birthplace Germany

MOTHER 14. Maiden Name Mary Lehr

15. Birthplace Germany

16 (a) Informant Miss Marie E. Schange

(b) Address 2321 Harlem Ave. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18, 1948 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Ave. Balto.

18 (a) Funeral director Easton Sons

(b) Address 608 Frederick Ave. Catons

NOV 17 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948 at 7:57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 19 48 to Nov 15 19 48 and that I last saw h er alive on Nov 15 19 48.

Immediate cause of death Carcinoma of lung metastatic to lung Ca of breast

Due to Carcinoma of breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Apr 1941

Major findings of operation: Ca of breast

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hab Bender M.D.

Address 1517 E North Ave Date signed 11/16/48

VS 150

BC-DD-2063 668656

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 668656

CERTIFICATE OF DEATH

81a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University 12 + 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 744 Reservoir St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Ann Ladnier

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 25 1948

8. AGE: Years | Months | Days | If less than one day: hr min.
7 weeks 2

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant.

11. Industry or business

FATHER
12. Name Charles Ladnier
13. Birthplace Alabama.

MOTHER
14. Maiden Name Ann Shields
15. Birthplace Pennsylvania

16 (a) Informant Mother
(b) Address 744 Reservoir St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)
(c) Cemetery or crematory MC Ador
Location MC Ador Pennsylvania

18 (a) Funeral director Wm Cook Bro.
(b) Address 1217 St Paul St

19 (a) Nov 17 1948 (Date rec'd by registrar) (b) Livingston Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1948 at 6 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1948 to Nov. 16 1948 and that I last saw her alive on 11/16 1948.

Immediate cause of death	Duration
Respiratory Paralysis	
Due to E. Coli meningitis	2 wks (?)
Due to	
Other Conditions — (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Phenelan Jr. M.D.
Address Univ. Hosp. Date signed 11/16/48

NOV 17 1948

VS .189

G68657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. G68657

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2101 W Cold Spring Lane

(c) Hospital or institution: Cold Spring Nursing Home 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Months

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3911 Ridgecroft Rd. (If rural, give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosa B. March

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife David S. March

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1868

8. AGE: Years	Months	Days	If less than one day: hr.	min.
80	9	8		

9. Birthplace Virginia (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Barger

13. Birthplace Virginia

MOTHER

14. Maiden Name Mollie Farns

15. Birthplace Virginia

16 (a) Informant James C. Harrison

(b) Address 3911 Ridgecroft Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-48 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Ave.

18 (a) Funeral director Wm. Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) (b) Huntington Williams M.D. Registrar

NOV 18 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1948 to Nov 15 1948 and that I last saw h[illegible] alive on Nov. 15 1948

Immediate cause of death	Duration
INTESTINAL OBSTRUCTION	48 hrs.
Due to STRANGULATED. Rt. INGUINAL HERNIA	4 days.
Due to	
Other Conditions CEREBRAL ARTERIOSCLEROSIS (Include pregnancy within 3 months of death)	10 yrs.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work)

(e) Means of injury

23. Signature Norman R. Klaman M.D.

Address 3803 Edmondson Ave Date signed 11/17/48

68658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 68658

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Road
(c) Hospital or institution: Beech Hill Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County [illegible]
(c) City or town Rodgers Forge (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 Dunkirk Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHRISTINA SCHMIDT

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Adolph
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 3, 1868

8. AGE: Years: 80 | Months: 2 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: John Mueller
13. Birthplace: Geermany

MOTHER
14. Maiden Name: Christina (Unknown)
15. Birthplace: Germany

16 (a) Informant: Charles T. Mahan
(b) Address: 322 Dunkirk Road, Rodgers Forge

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Parkville, Md.

18 (a) Funeral director: William Cook, Inc
(b) Address: 1217 St. Paul St.

19 (a) Nov 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18, 1948 19 at 11 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1941 to Nov 18 1948, and that I last saw her alive on Nov 18 19 4

Immediate cause of death: Cardiac failure — Duration

Due to: Arteriosclerosis

Due to:

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature: [illegible] M.D.
Address: 6028 York Rd
Date signed 11/17/48 M D

VS 150

68659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68659

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4649 Harcourt Rd
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4649 Harcourt Rd (If rural give location)
(e) Citizen of foreign country? — Yes or No
If yes, name country —

3 (a) FULL NAME Mary E. A. Coburn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Thos. H. Coburn

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Mar. 26. 1866

8. AGE: Years 82 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Talbot Co. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Q. Adams
13. Birthplace Talbot Co.

MOTHER
14. Maiden Name Ann M. Dulin
15. Birthplace Talbot Co.

16 (a) Informant Mrs. Anna Penn
(b) Address 4649 Harcourt Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18. 48 (Month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Catlett ave Rd

18 (a) Funeral director L. Hemmann & Son
(b) Address 6067 Harford Rd

19 (a) NOV 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15. 1948. at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15, 1948. to Nov 15 1948. and that I last saw her alive on Nov 15 1948.

Immediate cause of death Chronic Myocarditis — Duration

Due to Arterio-sclerotic Cardio vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Thomas E. Hall, M.D.
Address 1331 E. North Ave Date signed 11-17-48.

VS 150

Medical Examiner's Case

CERTIFICATE OF DEATH

8660 — 61

Registered (Medical)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2035 Guilford ave #18 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY C WARD Jr. (HENRY (HARRY) CLAY WARD, JR.

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lola M. Ward

6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Sept 24 1882

8. AGE: Years: 66 | Months: 1 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Retired Railroad worker

11. Industry or business

FATHER
12. Name: Henry C Ward Sr.
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Ella Hines
15. Birthplace: Baltimore Md.

16 (a) Informant: Mrs. Lola M. Ward
(b) Address: 2035 Guilford ave #18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/48 (month) (day) (year)
(c) Cemetery or crematory: Greenmount cem.
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 NOV 18 1948 (Date received by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 · 15 1948, at 11:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11 · 9 1948, to 11 · 15 1948, and that I last saw him alive on 11 · 15 1948

Immediate cause of death: Cardio-Respiratory failure - following general anesthesia — Duration:

Due to: Arteriosclerosis

Due to: Diabetes Mellitus

Other Conditions: T & P R Dawes

(Include pregnancy within 3 months of death)

CERTIFICATION APPROVED BY: Thomas T. Mallon, M.D.

Date of operation 11 · 15 · 48

Major findings of operation: Pocket in post under Scalp of post

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence: Nov. 15, 1948 at 11 A.M.
(c) Where did injury occur? Maryland General Hospital (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? No (Specify type of place)
(e) Means of injury: administration of sodium Pentothal anesthesia

23. Signature: Richard L. Martin M.D.
Address: Maryland Gen. Hosp. Date signed 11/15/48 M. D.

To be approved by Medical Examiner

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correct are is especially important. Physicians: please write the causes of death clearly and legibly.

668661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. 668661

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 69 days
(e) Length of stay in Baltimore (yrs., mos., or days): ?

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1737 Ashburton St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: DAVID CARRINGTON YOUNG

3 (b) If veteran, name war: SAW

3 (c) Social Security Account No.: --

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie Young

6 (c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Feb. 26, 1874

8. AGE - Years: 74 | Months: 8 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER
12. Name: Carrington A. Young
13. Birthplace: DC

MOTHER
14. Maiden Name: Cornelia Hergesheimer
15. Birthplace: DC

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/18/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 18 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 19 48, at 10:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 19 48 to Nov. 15 19 48, and that I last saw him alive on Nov. 15 19 48

Immediate cause of death: Carcinoma of urinary bladder — Duration: Unknown

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: S.F. van Ackeren, Medical Director
Address: Medical Officer in Charge Date signed: 11/15/48

V S 150

Patients wife gave age & date of birth as: Feb. 26, 1873
75 yrs. 8 mos. 19 das.

G68662

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

102

Registered No. G68662

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 741 Sarah ann st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Everett Cornish

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23, 1910.

8. AGE: Years	Months	Days	If less than one day: hr.	min.
38	2	24		

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Construction

FATHER
12. Name Charles Cornish.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Rosie Dimby.
15. Birthplace Baltimore Md.

16 (a) Informant Rosie D. Cornish.
(b) Address 741 Sarah Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St

19 (a) Nov 18 1948 (Date received by registrar) (b) Huntington Williams, Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16-48 19 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-15-48 19 to 11-16-48, and that I last saw h[illegible] alive on 11-16-48 19

Immediate cause of death	Duration
Respiratory failure	
Due to Hypostatic Encephalopathy	
Due to Malignant Hypertension	
Other Conditions Uremia	

(Include pregnancy within 3 months of death.)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. Hahn
Address University Hosp. Date signed 11-17-48 M D

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68663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 68663

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otis Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Della Taylor.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 6, 1878.

8. AGE: Years 70 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Northumberland Co., Va. (Town, county, and state)

10. Usual Occupation Baker.

11. Industry or business

FATHER
12. Name Daniel Taylor.
13. Birthplace Northumberland Co. Va.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Northumberland Co. Va.

16 (a) Informant Della Taylor
(b) Address 515 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 18, 1948. (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Huntington / Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15 1948. at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1948. to 11-15 1948. and that I last saw h(M) alive on 11-13 1948.

Immediate cause of death Arterio Sclerotic Cardio Renal Disease — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris M. D.
Address 1824 W. Franklin St. Date signed 11-15-48

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

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668664

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 170c

Registered No. 668664

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Freetown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KERMIT COATES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years	Months	Days	If less than one day
28			hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Otto Coates
13. Birthplace Maryland

MOTHER
14. Maiden Name Hattie Harris
15. Birthplace Maryland

16 (a) Informant: Otto Coates
(b) Address Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18 48 (month) (day) (year)
(c) Cemetery or crematory Marley Manley Neck
Location A A Co, Md

18 (a) Funeral director Israel L Brown for
(b) Address 1086 Montgomery St Huntingtown Williamsburg, Md

19 (a) NOV 18 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1948, at 12.45 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull.

Intracranial hemorrhage.

~~Due to~~ Contusion of brain.

Terminal pneumonia.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-13-48 at 6.30 p. M.
(b) Where did injury occur? Sollers Rd. A.A. Co., Md.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury truck into ditch

23. Signature [illegible] M.D. Medical Examiner.
Date signed November 16, 1948

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. yrs., mos., or days
(e) Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(d) Street No.
(e) Citizen of foreign country? If yes, name country

3 FULL NAME HAH

3 If veteran, name war (c) Social Security Account No.

4. Sex 5. Color or race 6. Single, married, widowed, or divorced

6 Name of husband or wife (b) If alive, give age years

7. (a) Date of death (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 NOV 18 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH M

21. I certify that I last saw deceased on Oct 23 46 and that death occurred at

Immediate cause of death

Due to

Due to

Other Conditions

PHYSICIAN

Date of operation

Major findings of operation:

of autopsy:

22. If death was caused by external causes fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(d) Did injury occur about home, on farm, in industrial place, or in public place?

(e) Means of injury

23. Signature

Address Date signed

668666

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

668666 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 N. Fulton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Peters

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 29 1872

8. AGE: Years	Months	Days	If less than one day
76	1	19	18 hr. min.

9. Birthplace Bristol R.I. (Town, county, and state)
10. Usual Occupation Waterman
11. Industry or business Md. Life Ins. Co.

FATHER
12. Name Richard Peters
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Fogarty
15. Birthplace Ireland

16 (a) Informant Margaret Anne Peters
(b) Address 1610 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave. Emerging for Williamsport

NOV 18 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1948, at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1948 to Nov 17 1948, and that I last saw h[illegible] alive on Nov 15 1948.

Immediate cause of death	Duration
Coronary Thrombosis	11/17/48
Due to	
Due to Chr. Myocarditis	1947
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1663 N. North Ave. Date signed 11/17/48

VS 150

...ORE CITY HEALTH D... ...TION

CERTIFICATE OF D...TH 92

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1750 HANOVER ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1750 HANOVER ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** BERNARD SIMON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MARY. SIMON
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) SEPT 3 - 1858

8. AGE: Years	Months	Days	If less than one day
90	2	13	hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation RETIRED BAKER
11. Industry or business

FATHER
12. Name CONRAD SIMON
13. Birthplace GERMANY.

MOTHER
14. Maiden Name SOPHIA. SCHROEDER.
15. Birthplace GERMANY.

16 (a) Informant MARY. SIMON (WIFE)
(b) Address 1750 HANOVER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV-20-48 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A. A. Co.

18 (a) Funeral director Bernard E. Hartman
(b) Address 121 E West St

19 (a) NOV 18 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 16 1948, at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 19 48 to Nov 16 19 48.
and that I last saw h— alive on Nov 15 19 48.

Immediate cause of death: Cerebral thrombosis
Due to
Due to
Other Conditions: Arteriosclerosis, hypertension.
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
—
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Schrand, M.D.
Address 1337 Edmondson Ave Date signed 11/19/48

VS 150

...ness use is especially important. Physicians: please write the causes of death clearly and legibly.

668668

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

178c

668668 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Grinald Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES M. WOOD, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Helen Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6, 1908

8. AGE: Years 40 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Captain (Tugboat)

11. Industry or business Maryland Drydock

FATHER
12. Name Charles M. Wood, Sr.
13. Birthplace West Virginia

MOTHER
14. Maiden Name Sarah Coppage
15. Birthplace Maryland

16 (a) Informant Mrs. Helen Ruth Wood
(b) Address 1915 Grinald Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd.

18 (a) Funeral director Edward Lowndes
(b) Address 2059 Wash. Blvd

NOV 18 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1948 at 7:20 A. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-17-48 at ? A. M. 256
(b) Where did injury occur? Maryland Dry Dock, Fairfield
(c) Did injury occur at home, on farm, in industrial place, or public place? Industrial While at work? yes
(d) Means of injury Inhalation of carbon monoxide

23. Signature Earle Boyd M.D.
(Medical Examiner.)
Date signed 11-17-48

VS 151

668669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668669

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town York (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 S. George St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Kuntz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Mrs. Mary Kuntz
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr) 5-16-88

8. AGE: Years 60 | Months 6 | Days 1 | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Surveyor
11. Industry or business

FATHER
12. Name Charles Kuntz
13. Birthplace Pa.

MOTHER
14. Maiden Name Emma Beecher
15. Birthplace Pa

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location York, Pennsylvania

18 (a) Funeral director Wm Cook Co.
(b) Address 1217 St Paul St.

NOV 18 1948 (Date rec'd by registrar) Washington Williams M.D. (Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1948 to 11-17 1948, and that I last saw him alive on 11-17 1948.

Immediate cause of death: Carcinoma of Stomach with Metastases — Duration: 2 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 10-15-48
Major findings of operation: Carc. Stomach generalized peritoneal implant
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Handelsman
Address Johns Hopkins Date signed 11-18-48 M. D.

VS 150

G68670 C.F.P. 275 ✓ G68670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 N. Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE CAMPBELL

3 (b) If veteran, name war —— | 3 (c) Social Security Account No. ——

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife ——
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
5			hr. min

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation ——
11. Industry or business ——

FATHER
12. Name Leonard Agleston
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Edna Campbell
15. Birthplace Baltimore, Md.

16 (a) Informant Angest Gilbert
(b) Address 1607 Edmondson Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Anne Arundel, County

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Mount Street

NOV 18 1948 Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 9:15PM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
2nd and 3rd Degree Burns
85% body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [X] or contributing [ ] cause of death, fill in the following:
(a) Date of injury 11-17-48 at 8:00 P. M.
(b) Where did injury occur? 315 N. Carey Street
(c) Did injury occur at home, on farm, in factory, in public place? home While at work? No
(d) Means of injury Trapped in burning room

23. Signature P. J. Gilbertie M.D. (Medical Examiner)
Date signed 11/18/48

VS 151

G68671

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

180

G68671
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 N. Carey Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CARRIE CAMPBELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years: 50 | Months: | Days: | If less than one day: hr. min

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: Louis R. Grant
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Isabella Anderson
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Agnest Gilbert
(b) Address: 1607 Edmondson Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary Cem.
Location: Anne Arundel County, Md.

18 (a) Funeral director: Metropolitan Life Ins. Co.
(b) Address: 927 N. Mount Street

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

Nov 18 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 9:15PM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: 2nd and 3rd Degree Burns 75% Body

Due to

Other Conditions: Internal chest injuries

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-17-48 at 8:00 P. M.
(b) Where did injury occur? 315 N. Carey Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury: House afire--Jumped from 3rd floor window

23. Signature: [illegible] M.D. Medical Examiner.
Date signed 11/18/48

G68672

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68672 ✓ Registered No. 180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 N. Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: DAISY GRANT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife ———
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
42 amt			hr. min.

9. Birthplace Baltimore, (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Louis R. Grant
13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Isabella Anderson
15. Birthplace Baltimore, Maryland

16 (a) Informant Agnes Gilbert
(b) Address 1607 Edmonson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Anne Arundel Co., Md.

18 (a) Funeral director Metropolitan Funeral Home, Inc.
(b) Address 927 N. Mount Street

19 (a) 11-18-48 (Date rec'd by Registrar) (b) Huntington Williamsport, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 9:15 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-17-48 at 8:00 P.M.
(b) Where did injury occur? 315 N. Carey Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury House fire--jumped from third flr. window

23. Signature [illegible] M.D. (Medical Examiner.)
Date signed 11/18/48

G68673

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12 B

Registered No. G68673

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 833 McKim St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 833 McKim St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward J. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Carlyn Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 25-1903

8. AGE: Years	Months	Days	If less than one day: hr.	min.
45	2	22		

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name John N. Smith
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Miller
15. Birthplace Balto. Md.

16 (a) Informant Carlyn Smith
(b) Address 833 McKim St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 19/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director John H. Miller
(b) Address 2334 Jefferson St.

19 (a) (Date rec'd by registrar) (b) Registrar Mary V. Williams

NOV 18 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1948 at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 1948 to October 1948 and that I last saw h alive on October 1948.

Immediate cause of death Tuberculosis of lungs, laryngeal and intestine. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. E. Thompson M.D.
Address 623 E. N. Ave. Date signed Nov 18/48 M. D.

668674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

668674
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2102 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 years

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Fleet Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Tomaszewski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Theodore Tomaszewski 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 1874

8. AGE: Years	Months	Days	If less than one day
74	3	21	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Theodore Tomaszewski
13. Birthplace Poland

MOTHER
14. Maiden Name Anna ?
15. Birthplace Poland

16 (a) Informant Mrs. Valeria Sabalewski
(b) Address 619 S. Belnord ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary cemetery
Location Baltimore County

18 (a) Funeral director John J. Weber
(b) Address 40 S. Chester Street Williamsport, Md.

19 (a) 11 18 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION 430

20. DATE OF DEATH Nov 16 1948 at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1948 to 11/16 1948. and that I last saw h alive on Nov. 15. 1948.

Immediate cause of death Senility

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration
—
years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond R. Nowak M. D.
Address 406 S. Patterson Park Ave. Date signed 11/17/48

VS 3

G68675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G68675

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2703 Eastern ave
(c) Hospital or institution: 1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 64 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Eastern ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Antoinette Rakowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widow

6 (b) Name of husband or wife Walenty Rakowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25 1879

8. AGE: Years	Months	Days	If less than one day
69	7	20	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Antoni Jarzynski
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Sabus
15. Birthplace Poland

16 (a) Informant Mrs Pauline Karol
(b) Address 2703 Eastern ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 19 1948 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 402 S. Chester Street

19 (a) Nov 18 1948 (b) Victor Williams, M.D.
(Date received by Registrar) Registrar

VS 8

MEDICAL CERTIFICATION

935

20. DATE OF DEATH Nov 14 1948, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 19 48, to Nov. 14 1948, and that I last saw h[illegible] alive on Nov. 14 1948.

Immediate cause of death Carcinoma of Liver & Bile Tract (Primary)

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 524 Eastern Date signed

To be checked by chief Med Examiner

G68676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G68676

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Gold Street
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Wright, Mary

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1867

8. AGE: Years	Months	Days	If less than one day: hr.	min.
81 79	10 8	15		

9. Birthplace Howard County, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alexander Mace
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Sophie Oliver
15. Birthplace Howard Co. Md.

16 (a) Informant Mrs. Lena Major
(b) Address 408 Gold St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 19, 19 48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mr. Earl Gilmour
(b) Address 519 N. Monroe St.

19 (a) NOV 18 1948 (mo., day, year) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1948, at 6 23 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1948 to 11/15 1948, and that I last saw her alive on 11/15 1948.

Immediate cause of death Hypostatic Pneumonia — Duration

Due to Comminuted fracture of Left Neck of Femur

Due to Generalized arteriosclerosis

Other Conditions

CERTIFICATION APPROVED BY
PHYSICIAN
M. D.
CHIEF OR ASST. MEDICAL EXAMINER

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 14/3
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10/25/48 at 10 A.M.
(c) Where did injury occur? Baltimore Maryland
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down steps at home

23. Signature Dr Marcus W. Moore
Address Provident Hospital Date signed 11/17/48 M. D.

VS 150

To be printed or written clearly and legibly.

668677

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668677 ✓ Registered No. 164c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 S. Carrollton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: RUSSELL SPAYD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mary E. Hoffman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1914

8. AGE: Years	Months	Days	If less than one day
34	3	16	hr. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual Occupation: Soldier In U.S. Army

11. Industry or business

FATHER
12. Name: Frank Spayd
13. Birthplace: Pennsylvania

MOTHER
14. Maiden Name: Sallie Keller
15. Birthplace: Pennsylvania

16 (a) Informant: Mary E. Spayd
(b) Address: 101 S. Carrollton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (yr.)
(c) Cemetery or crematory: Baltimore National
Location: Frederick Ave. Balto. Md.

18 (a) Funeral director: Lilly & Zeiler, Inc.
(b) Address: 403 South Wolfe Street Balto.

19 (a) NOV 18 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1948, at 8 P. M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Gunshot wound of head involving brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-15-48 at 6:30 P. M.
(b) Where did injury occur? 101 S. Carrollton Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Firearms

23. Signature C. J. Sullivan M.D. (Medical Examiner)
Date signed 11/16/48

VS 191

G68678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G68678

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3820 Chatham Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 Chatham Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY HAMMERSLEY

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 7, 1878

8. AGE: Years	Months	Days	If less than one day
70	3	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William N. Hammersley
13. Birthplace Md.

MOTHER
14. Maiden Name Esther V. Magers
15. Birthplace Md.

16 (a) Informant Miss Olive Hammersley
(b) Address 3820 Chatham Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 18 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948, at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943 to Nov 1948, and that I last saw h[illegible] alive on Nov 14 1948.

Immediate cause of death: Carcinomatosis — Duration

Due to Carcinoma of left breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation May 1943

Major findings of operation: Carcinoma of left breast

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Reich M.D.
Address 101 N. Read St Date signed 11/17/48

Countersigned for Williams, M.D. Registrar

VS 150

G68679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47a

Registered No. G68679

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 minutes
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Reisterstown (If outside city or town limits, write RURAL and give town)
(d) Street No. Church Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Asa Albert Taft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Married

6 (b) Name of husband or wife Matilda M. Taft
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 29, 1883

8. AGE: Years	Months	Days	If less than one day
64	11	20	hr. min.

9. Birthplace Jersey City N.J. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Theodore P. Taft
13. Birthplace New York

MOTHER
14. Maiden Name Narcissa Ashby
15. Birthplace New York

16 (a) Informant Mrs. Edward Taft
(b) Address Reisterstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory Glenwood Cemetery
Location Long Branch N.J.

18 (a) Funeral director J. F. Elsin & Sons
(b) Address Reisterstown, Md.

19 NOV 18 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1948, at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3:25 P.M. Nov. 17 1948 to Nov. 17 1948 and that I last saw h[illegible] alive on Nov. 17 1948.

Immediate cause of death	Duration
Asphyxia	
Due to Laryngeal obstruction	
Due to Carcinoma	
Other Conditions CERTIFICATION APPROVED BY PHYSICIAN	

(Include pregnancy within 3 months of death)

Date of operation Howard J. Mettler
Major findings of operation: CHIEF OF ABST. MEDICAL EXAMINER

of autopsy:

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Hunter M.D. M. D.
Address Univ. Hospital Date signed 11-17-48

VS 150

68680 Ost 6

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 92 D

68680 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 S. Madeira St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Goldsborough
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1884

8. AGE: Years	Months	Days	If less than one day
64	9	18	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Goldsborough
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Brooks
15. Birthplace Maryland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave
18 (a) Funeral director John A. Moran
(b) Address 3000 E. Balt. St.
19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

NOV 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17 1948, at 100 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 1948 to 11-17 1948, and that I last saw him alive on 11-17 1948.

Immediate cause of death Myocardial Infarction - acute — Duration

Due to Arteriosclerotic Cardiovascular Disease

Due to Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Jackson M. D.
Address The Johns Hopkins Hosp. Date signed 11/19/48

X

VS 150

668681

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

668681 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 E. Pratt Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY (or) Maria STELLA

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-7492

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anthony
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) 7-31-70

8. AGE: Years 78 | Months 3 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Bruno Stout
13. Birthplace Italy

MOTHER
14. Maiden Name Theresa Chumboti
15. Birthplace Italy

16 (a) Informant: Anthony Stella
(b) Address 1806 E. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20 48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4600 Belair Rd

18 (a) Funeral director Degnan Bros.
(b) Address 1800 E. Lombard St.

19 (a) NOV 18 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, 11:30 PM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Lubinski M.D.
Medical Examiner.
Date signed 11-18-48

VS 51

68682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

34a

Registered No. 68682

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster-
(If outside city or town limits, write RURAL and give town)
(d) Street No. 54 Webster street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE A. CHEW

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 218-09-9453

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Myrtle Coker Chew

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.): April 29, 1906

8. AGE: Years 42 | Months 6 | Days 19 | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Unknown

11. Industry or business

FATHER
12. Name: Arthur C. Chew
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Martha E. Allgire
15. Birthplace: Maryland

16 (a) Informant: Mrs. Myrtle Chew
(b) Address: Westminster, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/21/48 (month) (day) (year)
(c) Cemetery or crematory: Westminster
Location: Westminster, Maryland

18 (a) Funeral director: J. Francis Grace
(b) Address: Westminster, Md.

19 (a) Date received by Registrar: NOV 18 1948 (b) Registrar: Countryman for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Nov 1948 at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Nov 1948 to 18 Nov 1948 and that I last saw him alive on 18 Nov 1948

Immediate cause of death: Septicemia — Duration:

Due to: Causes unknown

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: None

of autopsy: Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence: None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: J. P. Young M.D.
Address: V.A. Hospital Date signed: 18 Nov 48

VS 150

068683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

838

Registered No. 068683

1 PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3224 Elliott St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3224 Elliott St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara Anna Poland

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry W. Poland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25 - 1875

8. AGE: Years	Months	Days	If less than one day
73	8	24	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name	Frank Tooby
FATHER 13. Birthplace	Germany
MOTHER 14. Maiden Name	Catharine Momberger
MOTHER 15. Birthplace	Germany

16 (a) Informant Henry W. Poland

(b) Address 3224 Elliott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22-48 (month) (day) (year)

(c) Cemetery or crematory Saint Matthews

Location Balto Md

18 (a) Funeral director Ellsworth Chapel

(b) Address 911 Liberty Heights Ave

19 NOV 18 1948 Huntington Williams, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 18 19 48 at 6.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 1 19 48 to NOV. 18 19 48, and that I last saw her alive on NOV. 17 19 48.

Immediate cause of death	Duration
CEREBRAL EMBOLISM	2 days
Due to GENERALIZED ARTERIOSCLEROSIS	10 yrs.
Due to	
Other Conditions PARKINSONISM	6 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Benjamin Kirshstein M. D.

Address 121 S. Hilton Ave Date signed 11-18-48

VS 150

668684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 668684

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4517 Eastern Ave.
(c) Hospital or institution: 26-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4517 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN R. SNIDER

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-6780

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary Snider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1889

8. AGE: Years	Months	Days	If less than one day
59 61	7	24	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Machinest

11. Industry or business Crown Cork & Seal Co.

FATHER
12. Name John H. Snider
13. Birthplace Carroll Co.

MOTHER
14. Maiden Name Sally Pinkins
15. Birthplace Carroll Co.

16 (a) Informant Mary Snider
(b) Address 4517 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 19, 1948 (month) (day) (year)
(c) Cemetery or crematory Baust Church Cem.
Location Carroll Co.

18 (a) Funeral director WENDELL J. DIPPEL
(b) Address 312 S. Highland Ave.

19 (Nov 18 1948 (rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1948, at 10 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [x] accident [ ] suicide [ ] homicide [ ] undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place or public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D., per Howard J. Sinclair Medical Examiner. M.D.

Date signed 11/18/48

VS 151

G68685

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68685,
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2623 E. MADISON ST. (If rural give location)
(e) Citizen of foreign country? NO. Yes or No
If yes, name country

3 (a) FULL NAME FRANK W. RUZICKA

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	MARRIED

6 (b) Name of husband or wife ROSEANNA RUZICKA (nee Kinzer)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) October 1, 1906

8. AGE: Years	Months	Days	If less than one day
42	1	15	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation POLICEMAN
11. Industry or business

FATHER
12. Name Frank Ruzicka
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Mary Charvat
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Rosa Kinzer Ruzicka - wife
(b) Address 2623 E. Madison Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Rose St. Balto. Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-5-5 E. Madison Street

19 (a) 11-18-1948 (Date received by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948 at 8:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3, 1948 to Nov. 16, 1948 and that I last saw him alive on Nov. 16, 1948.

Immediate cause of death: Typhoid Fever — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank W. Baker, M.D.
Address St. Joseph's Hospital Date signed 11-16-48

VS 150

688686

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170c

688686 6

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [redacted]
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Church Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMIL FRANK CISAR, SR.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Barbara M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1885

8. AGE: Years	Months	Days	If less than one day
63	10	2	hr. min

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Coast Guard
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Czech.

MOTHER
14. Maiden Name Unknown
15. Birthplace Czech.

16 (a) Informant Barbara M. Cisar
(b) Address 1413 Church St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 11-19-48 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd

18 (a) Funeral director J. Thompson Keene Jr.
(b) Address 26 W. Madison St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1948, 10.57 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of Pelvis

Due to

Other Conditions
Fracture Skull
Fibrillation
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-15-48 at approx. 7.00 P. M.
(b) Where did injury occur Church St., 24' from Pruden
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury pedestrian struck by auto

23. Signature Earl L. Royster M.D. (Medical Examiner)
Date signed November 16, 1948

VS 151

8687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8-2a

Registered No. 668687

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3119 Maryland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Inez Rigney

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2-4-09

8. AGE: Years	Months	Days	If less than one day
39	9	13	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Gallatin
13. Birthplace Pa.

MOTHER
14. Maiden Name Clara Sherry
15. Birthplace Pa.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery or crematory Woodland Cemetery
Location Baltimore Md.

18 (a) Funeral director Thomas J. Fox
(b) Address 1219 E. Fort Ave.

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 9.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 1948 to 11-17 1948, and that I last saw her alive on 11-17 1948

Immediate cause of death	Duration
subarachnoid and ventricular hemorrhage	hours.
Due to Cerebral arteriosclerosis	years.
Due to Hypertension	years.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Subarachnoid & ventricular hemorrh.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Anthony J. Rizzo. M. D.
Address Johns Hopkins Hosp. Date signed 11-18-48

VS 150

688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 688688

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 76
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4221 Shamrock Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Elburn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widowed

6 (b) Name of husband or wife John W. Elburn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 5, 1866

8. AGE: Years	Months	Days	If less than one day
82	5	12	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles W. Leimbach
13. Birthplace Unknown

MOTHER
14. Maiden Name Caroline Unknown
15. Birthplace Germany

16 (a) Informant Mary A. Rosner
(b) Address 4221 Shamrock Avenue

17 (a) burial (b) Date thereof 11/20/48
(Burial, cremation, or remo...) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) NOV 19 1948 (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1940 to Nov. 16 1948 and that I last saw her alive on Nov 16 1948.

Immediate cause of death	Duration
Bronchopneumonia	11 days
Due to	
Due to	
Other Conditions Generalized arteriosclerosis - Senility (Include pregnancy within 3 months of death)	?

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nelson C. Craig, M. D.
M. D.

Address 2117 Belair Rd Date signed 11-18-48

V3 150

8689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

668689 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edmondson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Bellona Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JEANNETTE A. KINNAIRD

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Raphael A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 14 1855

8. AGE: Years 92 | Months 11 | Days 3 | if less than one day ..... hr. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: (unknown) Mibler
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Alexander Kinnaird
(b) Address: 8 West 26th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore, Md.

18 (a) Funeral director: William Cook, Inc
(b) Address: 1217 St. Paul St.

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17, 1948 19 , at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 19 44 to Nov 17 19 48 and that I last saw her alive on Nov 17 19 48

Immediate cause of death: Chronic Myocarditis - Senility — Duration 4 yrs

Due to

Due to

Other Conditions: Arteriosclerosis - Senility; Chronic Nephritis
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature: Raphael Kinnaird
Address 112 W. 25th St. Date signed Nov 18 '48

VS 150

9.3 D

8690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G68690

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Street
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7224 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Hortense W. Gutman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Mr. Leo J. Gutman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1899

8. AGE: Years	Months	Days	If less than one day
49	7	10	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Whitehill
13. Birthplace Baltimore, md.

MOTHER
14. Maiden Name Laura Greif
15 Birthplace Baltimore md.

16 (a) Informant Mr. Leo J. Gutman
(b) Address 7224 Pk. Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery ~~accompany~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Sherwin Sonnenborn
(b) Address 1902 Eutaw Place

19 (a) NOV 19 1948 (b) Huntington Williams, M.D.
[To be filled in by registrar]

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at 1 55 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1948 to Nov. 19 1948, and that I last saw her alive on Nov. 18 1948

Immediate cause of death	Duration
Multiple metastasis	?
Due to Carcinoma of the Lung	6 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Graybeal M.D.
Address Union Memorial Hospital Date signed 11/19/48

H. C. GRAYBEAL

VS 130

591 3C-48-24992 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 15 E

Registered No. 668691

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town 544 Winston Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Ind (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH Mc GEE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-13-48

8. AGE: Years	Months	Days	If less than one day
0	0	4	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation infant
11. Industry or business

FATHER 12. Name James Mc Gee
13. Birthplace Balto Md

MOTHER 14. Maiden Name Betty Mc Ginty
15. Birthplace Balto Md.

16 (a) Informant Father - JAMES Mc GEE
(b) Address Same 544 Winston Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 19-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director CHAS F. EVANS & SON
(b) Address 118 W Mt Royal Ave

19 NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18-48 19 , at 1-55 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13- 1948. to 11-18- 1948.
and that I last saw him alive on 11-18- 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Congenital heart disease, agenetic group	4 hrs (4 days)
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature Allyn F. Judd M. D.
Address Mercy Hospital Date signed 11-18-48

VS 150

68692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 123

Registered No. 68692

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 524 Virginia Ave.
(c) Hospital or institution: Mordent Strauss
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 Cumberland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Esteen Branch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1921

8. AGE: Years 27 | Months 4 | Days 20 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laundry Worker

11. Industry or business

MOTHER / FATHER
12. Name Samuel P. Green
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Alice Ennis
15. Birthplace Calvert Co. Md.

16 (a) Informant Rev. Samuel P. Green
(b) Address 1209 Riggs Ave.

17 (a) Burial (b) Date thereof 11/23/1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Geo. Enright & Sheland
(b) Address 6431 Harford Rd.

19 (a) NOV 19 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17 1948 at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1948 to 11-17 1948 and that I last saw her alive on 11-17 1948

Immediate cause of death: Generalized Peritonitis — Duration

Due to 1: Subphrenic Abscess

Due to 2: Fecal Fistula

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-21-48; 11-8-48

Major findings of operation: Abscess - Fecal Fistula

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Bramhall Lehmayer

Address 1343 Roma Ave Date signed 11/19/48
M D

VS 150

68693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G68693

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 930 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 930 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISABELLE SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife James A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1877

8. AGE: Years	Months	Days	If less than one day
71	6	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant Mr. James A. Smith
(b) Address 930 Madison Ave.

17 (a) Burial (b) Date thereof 11/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 19 1948 (b) Evelyn Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 12:40 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11, 1948 to Nov 17, 1948.
and that I last saw her alive on Nov. 16, 1948.

Immediate cause of death
Chronic Myocarditis — Duration 1 yr.
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 450 W. Biddle St. Date signed 11/18/48

VS 150

68694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. G68694

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 Bloom Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Bloom Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) FULL NAME: SAMUEL J. CARROLL

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): July 21, 1869

8. AGE: Years 79 | Months 3 | Days 26 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Insurance solicitor

11. Industry or business

MOTHER | FATHER

12. Name: William Carroll
13. Birthplace: Baltimore, Maryland.

14. Maiden Name: Georginna Thomas
15. Birthplace: Baltimore, Maryland.

16 (a) Informant: Mrs. Rosa Driver
(b) Address: 2024 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 21, 1948 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Mrs. George H. Holland
(b) Address: 1631 Druid Hill Ave.

19 (a) NOV 19 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1948 at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1948 to Nov. 17 1948, and that I last saw him alive on Nov. 17 1948

Immediate cause of death: Cerebral hemorrhage — Duration: 24 hours

Due to: Essential Hypertension — ?

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 844 N. Carey St Date signed 11/18/48 M D

VS 150

68695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 68695

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Gibbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6/9/1863

8. AGE: Years	Months	Days	If less than one day
85	5	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth Green
15. Birthplace Md

16 (a) Informant Mary Moulton
(b) Address 913 Goodenough St

17 (a) Burial (b) Date thereof 11/19/48 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaac L Brown Son
(b) Address 108 W Montgomery St

NOV 19 1948 (b) [illegible] Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1948 at 3:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28, 1948 to Nov. 6, 1948 and that I last saw her alive on Nov. 15, 1948.

Immediate cause of death: Ch. Val. H. D. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. S. Taylor
Address 522 Harlem Ave Date signed 11/18/48

VS 150

0686596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

0686596 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Madison Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD McNAIR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	UNKNOWN

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace N (Town, county, and state)

10. Usual Occupation K

11. Industry or business N

FATHER
12. Name O
13. Birthplace N

MOTHER
14. Maiden Name UN
15. Birthplace KNOWN

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11.19.48 (month) (day) (year)
(c) Cemetery or crematory Payne Cem. Washington D
Location [illegible] NOV 4 1948

18 (a) Funeral director Commissioner of Health
(b) Address Stewart's Funeral Home, Washington

19 (a) NOV 10 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8, 1948, at 7.50p M

21. I certify that I took charge of the remains described above, held an Inquiry & Insbec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) If injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Royer M.D.
Medical Examiner.
Date signed November 9, 1948

58697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

✓ G68697 Registered No.

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 216 MALLOW HILL (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gilbert S. Powell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of ~~husband~~ or wife EDITH E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) JULY 24, 1897

8. AGE: Years	Months	Days	If less than one day hr	min.
51	3	23		

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name JOSEPH A POWELL
13. Birthplace MARYLAND

MOTHER
14. Maiden Name EMMA HANGARTER
15. Birthplace GERMANY

16 (a) Informant MRS GILBERT S POWELL
(b) Address 216 MALLOW HILL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 22 '48 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK RD

18 (a) Funeral director Harry A Wilhelm
(b) Address 4101 Edmondson Ave

19 (a) NOV 19 1948 (Date rec'd by registrar) Huntington Williams M D

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 17 1948 at 1350 PM

21. I certify that death occurred on the date above stated, that I attended deceased from NOV 1 1948 to NOV 17 1948 and that I last saw him alive on NOV 17 1948

Immediate cause of death: Circulatory Shock — Duration

Due to Gastric Bleeding

Due to

Other Conditions Peripheral Vascular Disease
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank E Eisenbach M D
Address University Hosp Date signed 11-17-48

VS 150

118

68698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 68698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(c) Street No. 1106 - N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME. Elizabeth Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married

6 (b) Name of husband or wife Lloyd Williams
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 3-24-92

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56	7	22		

9. Birthplace St. Mary Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Chas Dolley
13. Birthplace Md

MOTHER
14. Maiden Name Maggie Jackson
15. Birthplace Md.

16 (a) Informant Lloyd Williams
(b) Address 1106 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore, Md.

18 (a) Funeral director Mc Francis E Kenney
(b) Address 578 W. Biddle St

19 (a) NOV 19 1948 (b) Catherine Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18-48 1948 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15- 1948 to 11-18- 1948 and that I last saw her alive on 11-18- 1948

Immediate cause of death	Duration
Subarachnoid hemorrhage	
Due to Hypertension	
Due to	
Other Conditions Nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mayle I Woodall M.D.
Address 861 Hanlon Date signed 11-18-48

VS (5)

8699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. 68699

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 32 E. Pultney Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS ROSENBERGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW #2	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-11-10

8. AGE: Years	Months	Days	If less than one day
38	2	6	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Rosemberger
13. Birthplace Maryland

MOTHER
14. Maiden Name W. C. Seitz
15. Birthplace Maryland

16 (a) Informant Family
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location 5501 Frederick Avenue

18 (a) Funeral director JAMES L. McCULLY
(b) Address 130 East Fort Avenue

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 7:3[illegible] PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of head of Pancreas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 11/18/48

VS 151

8760.0a

Medical Examiner's Case
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1600

668700
Registered No.

I.C. 48-2599

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 N Central ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) N. B. 11/17/48
8. AGE: Years | Months | Days | If less than one day 2 hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Steven Johnson
13. Birthplace ?
MOTHER 14. Maiden Name Mary ?
15. Birthplace ?
16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director Joseph L. [illegible]
(b) Address 1307 N. Central Ave
19 (a) NOV 19 1948 (Date rec'd by reg'r) (b) Huntingtown, Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17- 1948 at 3.40 M
21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19
Immediate cause of death Prematurity
Due to Dead on Arrival
Due to
Other Conditions Subdural Hemorrhage
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

CERTIFICATION APPROVED BY:
Wm. H. Kammer, M.D.
Per [illegible] M.D.
CHIEF OR ASSN. MEDICAL EXAMINER.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address [illegible] Date signed 11-19-48

VS 150

To be approved by Med Ex.

68701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 124 B

✓ 68701 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. (b) County .....
(c) City or town Atlanta (If outside city or town limits, write RURAL and give town)
(d) Street No. 3651 Tuxedo Road (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME DAUGHTY R. MANLY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	DIVORCED

6 (b) Name of husband or wife Christine McEachern
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 22, 1903

8. AGE: Years	Months	Days	If less than one day
45	3	26	..... hr. ..... min.

9. Birthplace Atlanta (Town, county, and state)
10. Usual Occupation Merchant Marine
11. Industry or business

FATHER
12. Name W.D.Manley
13. Birthplace Georgia

MOTHER
14. Maiden Name Valeria Rankin
15. Birthplace Georgia

16 (a) Informant Mrs. Valeria R. Manley
(b) Address 3651 Tuxedo Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory .....
Location Atlanta, Ga.

18 (a) Funeral director Wm. J. Ticknor & Sons
(b) Address Baltimore, Md.

19 NOV 19 1948 (Date rec'd by registrar) (By) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1948, at 5:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary edema
Myocardial degeneration
Fatty Degeneration of liver

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury .....

23. Signature Earl M. Long M.D. (Medical Examiner)
Date signed 11-18-48

X

G68702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G68702

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Guilford Ave. & 34th St.
(c) Hospital or institution:
Temple Court Apartments
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Court Apts. Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kitty Livingston DeFarges

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed~~, or divorced. Married

6 (b) Name of husband or ~~wife~~ Herbert C. De Farges Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1883

8. AGE: Years 65 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edwin C. Livingston
13. Birthplace Unknown

MOTHER
14. Maiden Name Emma———
15. Birthplace Unknown

16 (a) Informant Mr. John L. De Farges (Son)
(b) Address Temple Court Apts. Balto.

17 (a) Nov. 19, 1948 (b) Date thereof
(Burial, ~~cremation~~, or ~~removal~~) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director William J. Tickner & Sons,
(b) Address 34th & Pennsylvania Aves.

19 (a) NOV 19 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1948, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 to 11/17 1948.
and that I last saw her alive on 11/16 1948.

Immediate cause of death: Carcinoma of the ovary
Due to: & peritoneal metastases.

Duration: 1 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George L. Livingston Jr. M.D.
Address 1114 St. Paul St. Date signed 11/19/48

VS 153

G68703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G68703 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4420 Falls Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1-2
(e) Length of stay in Baltimore (yrs., mos., or days) 43 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4420 FALLS RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH MARKOWITZ

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife JENNIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1895

8. AGE: Years	Months	Days	If less than one day
53			hr min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation TAILOR
11. Industry or business

FATHER
12. Name JONAS
13. Birthplace RUSSIA

MOTHER
14. Maiden Name DENA
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-19-48 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location Philadelphia Rd & HAMILTON AVE

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Pl. Baltimore, Md

19 (a) (Date received by Registrar) NOV 9 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 19 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 19 1948, and that I last saw him alive on 11/19 1948.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Chronic Hypertrophied Prostate	
Due to Ruptured Varicose Veins PERIPHERAL	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. C. Litman M.D.
Address [illegible] Balto Date signed 11/19/48

X

68704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 68704

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Shack in rear of 1620 Benhill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Shack in rear of 1620 Benhill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NICHOLAS CEBULSKI OR CYBULSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Know ?

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ? Cebulski
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant John Supy
(b) Address 1620 Benhill Ave.

17 (a) Burial (b) Date thereof Nov. 20, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Elkridge, Maryland

18 (a) Funeral director John A. Grebliauckas Jr.
(b) Address 423 S. Paca Street

19 (a) NOV 19 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17, 1948, at 3:50 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardio-vascular disease

Due to

over

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Carl L. Rogers M.D.
Medical Examiner.
Date signed 11/18/48

VS 151

X

668705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. 668705

668705

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4332 Old York Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Charles Ruppert

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-20-2532

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 2, 1925

8. AGE: Years 23 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business B & O

FATHER
12. Name George J. Ruppert
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Margaret Ruppert
15. Birthplace Maryland

16 (a) Informant Mrs. Anna M. Ruppert
(b) Address 4332 Old York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3006 E. Baltimore St. Huntington Nottingham, Md.

19 (a) NOV 19 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1948, at 6:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16/ 1948. to 11/19/ 1948.
and that I last saw him alive on 11/19/ 1948.

Immediate cause of death Congestive Failure — Duration

Due to Aortic stenosis and mitral stenosis

Due to Rheumatic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Rheumatic Heart Disease

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ray E. Reasons Jr. M.D.
Address St. Joseph's Hospital Date signed 11/19/48

VS 192

Physicians: please write the causes of death clearly and legibly.

58706

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

114D

Registered No. 58706

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkins Ave.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6819 Dunkill Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patrick L. Murphy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Widowed

6 (b) Name of husband or wife KATHLEEN E MURPHY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/8/1897

8. AGE: Years	Months	Days	If less than one day
51	5	9	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Machanist
11. Industry or business Bethlehem Steel

FATHER
12. Name Patrick Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Stenson
15. Birthplace Ireland

16 (a) Informant HARRY McCAMBRIDGE
(b) Address 6819 DUNKILL RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 20, 1948 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location 4300 OLD FREDERICK RD

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 DUNDALK AVE.

NOV 19 1948 Thurlington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1948 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1948 to 11/17/1948 and that I last saw him alive on 11/17 1948.

Immediate cause of death	Duration
CARDIO - RESPIRATORY FAILURE	
Due to LUNG ABSCESS	
2 GENERALIZED SEPTICEMIA	
Due to ENCEPHALITIS	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Shea M. D.
Address 1210 Eye & Ear Hosp. Date signed 11/19/48

VS 159

668707

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1242

Registered No. 668707

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Clifton Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
if yes, name country

3 (a) FULL NAME Thomas F. Sheehan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Georgia Applegarth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/29/1883

8. AGE: Years	Months	Days	If less than one day
65	9	19	hr. min.

9. Birthplace Md.
10. Usual Occupation Sr. Auditor - Comp Office
11. Industry or business State of Md.

FATHER
12. Name Cornelius Sheehan (dec)
13. Birthplace Ireland

MOTHER
14. Maiden Name Rose Cognan (dec)
15. Birthplace Ireland

16 (a) Informant Mrs. Georgia A. Sheehan
(b) Address 3602 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. F. Means and Son
(b) Address 805 N. Calvert St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18 1948, at 3.50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 1948, to 11/18 1948, and that I last saw him alive on 11/18 1948.

Immediate cause of death: Cirrhosis of the Liver
Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy: Cirrhosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert J. Knickes M.D.
Address St. Agnes Hosp. Date signed 11/19/48

VS 150

FRANK CROOKS

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G68708

G68708

462

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: University Hospital
(c) Hospital or institution: Balt. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Randallstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Crooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife: Mary Crooks

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr) Sept. 3, 1869

8. AGE: Years 79 Mos. Months 2 Days 17 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Runner

11. Industry or business

FATHER
12. Name John Crooks
13. Birthplace Maryland

MOTHER
14. Maiden Name Charolette Grimes
15. Birthplac Maryland

16 (a) Informant Mrs. Mary V. Crooks
(b) Address Randallstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive
Location Randallstown, Balto. Co. Md.

18 (a) Funeral director C. M. Waltz
(b) Address Winfield, Md.

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17-48 19 at 9 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10 1948 to 11-17 1948. and that I last saw h im alive on 11-17 1948

Immediate cause of death Respiratory collapse

Due to Metastatic Ca of Stomach

Due to

Other Conditions Arteriosclerosis & Benign Prostatic Hypertrophy

(Include pregnancy within 3 months of death)

Date of operation 11-12-48

Major findings of operation: Inoperable Ca of stomach with intestinal obst.

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. B. Pratt Jr. M.D.
Address University Hospital Date signed 11-17-48

VS 150

68709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. 68709

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3404 Walbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Walbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN CHESTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Anna Chester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 1, 1872

8. AGE: Years	Months	Days	If less than one day
76	3	17	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Charles Chester
13. Birthplace

MOTHER
14. Maiden Name Agnes Moreilas
15. Birthplace

16 (a) Informant Mrs. Anna Chester
(b) Address 3404 Walbrook Ave.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Maus.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 19 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1948, at 9:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 14 1948 to Nov 18, 1948, and that I last saw h[illegible] alive on 11/12 1948

Immediate cause of death Carcinoma of Prostate — Duration 4 years.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John P. Ulrich, Jr. M. D.
Address 1227 Wash Blvd Date signed 11/19/48

VS 150

068710

BALTIMORE CITY HEALTH DEPARTMENT X V Registered No. 068710

CERTIFICATE OF DEATH 51C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 Cleveland St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town 29 Wright Aileron St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES TURNBULL

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No.:

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Virginia E. Turnbull

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1916

8. AGE: Years 32 | Months 9 | Days 9 | If less than one day: hr. min.

9. Birthplace: Belfast, Ireland (Town, county, and state)

10. Usual Occupation: Inspector

11. Industry or business: Glenn Martin

FATHER
12. Name: Andrew Turnbull
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary A. Mawhinney
15. Birthplace: Ireland

16 (a) Informant: Mrs. Virginia E. Turnbull
(b) Address: 1216 Cleveland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery or crematory: Meadowridge Cem.
Location: Balto., Md.

18 (a) Funeral director: W. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 19 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948 at 4:40 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 5-18 1948 to 11/16 1948 and that I last saw him alive on 11/16 1948

Immediate cause of death: Carcinoma (Embryonal) left testicle — Duration: 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation June 1947

Major findings of operation: Embryonal left testicle

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich, Jr. M.D.
Address (22) Wash. Blvd. Date signed 11/19/48

VS 130

668711

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 939

668711 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 71 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. more (If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 Lake Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr William Dittmar

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-3975

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed.

6 (b) Name of ~~husband~~ or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 5, 1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71	4	10		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Wood worker
11. Industry or business John Dittmar & Sons Inc.

FATHER 12. Name John Dittmar
13. Birthplace Germany

MOTHER 14. Maiden Name Barbara Hess
15. Birthplace Germany

16 (a) Informant ~~Mrs Elsie~~ Mrs O.B. Colonta Jr.
(b) Address Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 NOV 19 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1948, at 1.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 19 48 to Nov 18 1948, and that I last saw him alive on Nov 18 19 48

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive Cardio Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature J. Frank Hopkins Jr.
Address Union Memorial Hosp. Date signed 11/19/48

VS 150

66871.2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 66871.2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2788½ The Alameda
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2788½ The Alameda (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE L. JOHNSON

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	212-07-8521	female	white	widow

6 (b) Name of husband or wife Murrill E. Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1891

8. AGE: Years	Months	Days	If less than one day
57	0	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Edward Hartman
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Annie Miller
15. Birthplace Gettysburg, Pa.

16 (a) Informant Mrs. Katherine Stromyer
(b) Address 2788½ The Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1948 at 10:45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1st 1948 to Nov. 16 1948 and that I last saw h[illegible] alive on Nov 16 1948

Immediate cause of death: Acute Cardiac Failure
Due to: Pulmonary Edema
Due to: Chronic Myocarditis & Hypertension

Duration: 1 day, unknown

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Ashman M.D.
Address 1420 W. Lafayette Ave Date signed 11/18/48

VS 150

G68713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. G68713

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Homestead (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Rebecca Fonshell
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Harry S Fonshell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-3-1877

8. AGE: Years 71 | Months 0 | Days 17 | If less than one day hr. min.

9. Birthplace Frederick, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William B. Shilling
13. Birthplace England

MOTHER
14. Maiden Name Ellie R. Castle
15. Birthplace Frederick, Md

16 (a) Informant Mrs. Wm Fonshell
(b) Address 1109 Homestead

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 19 1948 (Date rec'd by registrar) (b) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17 1948, at 5 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8 1948 to 11-17 1948, and that I last saw h e alive on 11-16 1948

Immediate cause of death	Duration
Obstruction of common bile duct	2 wks
Due to Gall Stone	
Due to Pyonephrosis & Stone in Kidney	3 yrs
Other Conditions ASHD 3rd °	

(Include pregnancy within 3 months of death)

Date of operation Nov 9
Major findings of operation:
of autopsy: Yes above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A Post M D
Address Church Home Date signed 11-17-48

VS 150

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X

68714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68714

157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N C (b) County
(c) City or town Gastonia (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 776 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Karen Patton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-16-48

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace N C (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Howard J. Patton

13. Birthplace N C

MOTHER 14. Maiden Name Nell McSwain

15. Birthplace N C

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-48 (month) (day) (year)

(c) Cemetery or crematory Gastonia

Location N. C.

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 112-22 Eutaw Pl. Huntington Williams, WVa

19 NOV 19 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1948 at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16- 1948 to 11-19 1948 and that I last saw h[illegible] alive on 11-19-1948.

Immediate cause of death Congenital Cardiac Malformation — Duration

Due to

Due to

Other Conditions Bilat. cleft lip and cleft palate (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac malformation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Ryan M. D.

Address Johns Hopkins Hosp Date signed 11/19/48

VS 150

68715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54B

Registered No. 68715

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1126 Forrest St.
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Forrest St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARLENE R. WALKER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Divorced

6 (b) Name of husband or wife: M onroe
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 19, 1916

8. AGE: Years	Months	Days	If less than one day
32	3	29	hr. min.

9. Birthplace: New York (Town, county, and state)
10. Usual Occupation:
11. Industry or business

FATHER
12. Name: Irving Bennett
13. Birthplace: N.Y.

MOTHER
14. Maiden Name: Mary Dewey
15. Birthplace: N.Y.

16 (a) Informant: Mrs Mary Snyder
(b) Address: 1126 Forrest St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)
(c) Cemetery or crematory: Meadow Ridge
Location: Dorsey Md

18 (a) Funeral director: William Cook, Inc.
(b) Address: 1217 St. Paul St.

19 (a) NOV 20 1948 (Filed by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18, 1948 19 . at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Nov 1948 to 18 Nov 1948, and that I last saw h alive on 17 Nov 1948.

Immediate cause of death: Hypostatic pneumonia — Duration: 2 Days
Due to: Brain tumor, recurrent. — 1 yr.
Due to: — over
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: 1947
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Dudley B Cogan, Jr M.D.
Address: 2893 St. Paul Date signed: 11-19-48

VS 150

68716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 68716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 Orlando Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Orlando Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RUTH COOK

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel B.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 23, 1893

8. AGE: Years 55 | Months 7 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lewis Packham
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Sweden
15. Birthplace Md

16 (a) Informant Evelyn Kalbshopf
(b) Address Ridgely Ave., Fullerton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Towson Md

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 20 1948 (Date received by Registrar) (b) Huntington Williams, M.D. (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1948 19 ____ at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 48 to Nov. 18, 19 48. and that I last saw her alive on Nov. 18 19 48.

Immediate cause of death: Hypertensive Cardio-Vascular disease. — Duration 10 yrs.

Due to Cerebral Hemorrhage

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan Janney M.D.
Address 7101 Harford Rd Date signed 11/19/48

VS 150

92

G8717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G6871.7

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4409 Maine Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4409 Maine Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELEANORA - SANDLASS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Richard E. Sandlass

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Jan. 22. 1874

8. AGE: Years 74 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Louis Kleinhenn
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Schmidt
15. Birthplace Germany

16 (a) Informant Richard E. Sandlass
(b) Address 4409 Maine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22 1948 (month) (day) (year)
(c) Cemetery or crematory Western
Location Catto-City

18 (a) Funeral director Mr. Mrs. John W. Teufel & Son
(b) Address 5311 Edmondson Ave

19 NOV 20 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1948, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Nov 19 1948, and that I last saw her alive on Nov 18 1949.

	Duration
Immediate cause of death: Coronary occlusion	4 hr
Due to: Hypertension Cardiovascular Renal	10 yr
Due to: Diabetes	30 yr
Other Conditions: Generalized Arteriosclerosis	10 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Thos J. Abbott M.D.

Address 4509 Liberty Heights Date signed Nov 20 48

V S 150

668718 — Bickle

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

✓ 668718 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga | 29
(c) Hospital or institution:
Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto, City
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1609 Kingsway Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Minnie Bickle (Wilhelmina — Known as Minnie)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed), or divorced.
F	W	

6 (b) Name of husband or wife John H. Bickle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3-14-1869

8. AGE: Years	Months	Days	If less than one day
79	8	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Wm. Dreemer
13. Birthplace Germany

MOTHER
14. Maiden Name Theodora Pfleich
15. Birthplace Germany

16 (a) Informant James Bracknell
(b) Address 1609 Kingsway Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22/48 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Balto Md

18 (a) Funeral director Ulbel Funeral Home
(b) Address 2008 Orleans St

19 (a) NOV 20 (Date rec'd by registrar) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 1948 at 9 5/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1948 to 11-19 1948, and that I last saw her alive on 11-19 1948.

Immediate cause of death	Duration
Generalized Hemmorrhage	
Due to Chronic leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Leukemic infiltration
of autopsy Gen. Hemmorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Harry Powell Jr. M D
Address Mercy Hosp Date signed 11/20/48

Harry Powell Jr

VS 150

G68719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68719

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Worcester
(c) City or town Snow Hill (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1707 E. Monument St~~ (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Wh | 6 (a) Single, married, widowed, or divorced. Wid

6 (b) Name of husband or wife Frank T. Bailey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1860

8. AGE: Years 88 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Snow Hill, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name William J. Bryden
13. Birthplace Maryland

MOTHER
14. Maiden Name Ann Riley
15. Birthplace Maryland

16 (a) Informant Mrs. William C. Jones Sr.
(b) Address Snow Hill, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22 48 (month) (day) (year)
(c) Cemetery or crematory Baley Mill
Location Snow Hill Md

18 (a) Funeral director Clay E. Dennis
(b) Address Snow Hill Md

19 (a) NOV 20 1948 (Date rec'd by registrar) (b) Thurston Worthington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 1948 at 10 03 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1948 to 11/19 1948, and that I last saw h alive on 11/19 1948.

Immediate cause of death

Duration

Respiratory
Due to Cerebrovascular accident
Due to Hypertension and arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Blazer M.D.
Address Date signed 11/19/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

668720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 528 N. WASHINGTON ST
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 N WASHINGTON ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME HOWARD D. DEAL

3 (b) If veteran, name war ----

3 (c) Social Security Account No. -----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Grace W. Deal
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1869

8. AGE: Years	Months	Days	If less than one day
79	0	5	____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Wm. Deal
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Eliza J. Duncan
15. Birthplace Balto. Md.

16 (a) Informant Miss Grace Deal
(b) Address 528 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22/48 (month) (day) (year)
(c) Cemetery or crematory St. John's Episcopal Cem
Location Balto. Md.

18 (a) Funeral director Philip Henrijsons
(b) Address 2024 Orleans St.

19 (a) NOV 20 1948 (b) Signature Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at 2.07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to Nov 19 1948, and that I last saw him alive on Nov. 18 1948.

Immediate cause of death
Cerebral Vascular hemorrhage — Duration 6 days
Due to Hypertension — Duration ?
Due to Arteriosclerosis — Duration ?
Other Conditions Blind in left eye
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ____ M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Melvin H. Borden, M.D.
Address 2030 W. Fayette Date signed 11/19/48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. 68721

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2108 Mt.Holly St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 Mt.Holly St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie V.Griffith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry M.Griffith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 25 1869

8. AGE: Years	Months	Days	If less than one day
79	1	25	24 hr. min.

9. Birthplace Cambridge Ohio
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name David Britton
13. Birthplace Virginia

MOTHER
14. Maiden Name Prudence DeSellems
15. Birthplace Cambridge Ohio

16 (a) Informant Anna B.Snyder
(b) Address 2108 Mt.Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24 1948 (month) (day) (year)
(c) Cemetery or crematory Uniontown
Location Kanass

18 (a) Funeral director Harry Ahrnacker
(b) Address 4204 Ridgewood Ave

19 (a) NOV 20 1948 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 19 48, at 11 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19 48, to Nov 19 19 48.
and that I last saw h alive on Nov 1 19 48.

Immediate cause of death Cerebral Embolism — Duration 4 days

Due to Cerebral Arteriosclerosis — Duration 4 yrs

Due to Pneumonia, Hypostatic — Duration 4 days

Other Conditions Diabetes Mellitus — Duration 4 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed

VS 150

8722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

✓ 668722 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution:
Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Dawson Reeder M.D.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of ~~husband~~ or wife Anne Carey Reeder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 16, 1880

8. AGE: Years	Months	Days	If less than one day
68	4	2	hr. min.

9. Birthplace Dorchester Co. Maryland (Town, county, and state)
10. Usual Occupation M.D.
11. Industry or business

FATHER
12. Name Charles M. Reeder
13. Birthplace Baltimore, Maryland.

MOTHER
14. Maiden Name K. M. Dawson
15. Birthplace Dorchester Co. Maryland

16 (a) Informant Home for Incurables records - C.E.
(b) Address 700 W. 40th St. Balt. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. McCall & Son, Inc.
(b) Address 1900 Eutaw Place

19 NOV 20 1948 (Date received by registrar) (b) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1948, at 6:50 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 10 1946 to Nov. 18 1948, and that I last saw h~~im~~ alive on Nov. 17 1948

Immediate cause of death Coronary Thrombosis — Duration 4½ days

Due to Hypertensive - Arteriosclerotic Cardio Vascular Disease — Over 5 years

Due to

Other Conditions Dental Caries and Oral Sepsis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolf M. D.
Address 11 E. Chase St Date signed 11-18-48

VS (5)

68723

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 68723

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4311 Pimlico Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4311 Pimlico Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James C. Dishon

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1872

8. AGE: Years	Months	Days	If less than one day
76	8	27	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Food Dispensary.

FATHER
12. Name David Dishon
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary C. Roach
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Margaret V. Dishon
(b) Address 4311 Pimlico Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Maryland

18 (a) Funeral director Lorenz Leith
(b) Address 5385 Reisterstown

19 (a) NOV 20 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1948, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1948, to Nov 18 1948, and that I last saw h— alive on Nov 18 1948

Immediate cause of death
Arteriosclerosis
Cerebral thrombosis
Duration 8 yrs. 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. H. Davis M.D.
Address 2818 Pa Ave Date signed 11/20/48 M. D.

VS 150

66724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 66724

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 704 Mc Henry St.

(c) Hospital or institution: -

(d) Length of stay in hospital or inst. (yrs., mos., or days) -

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 704 Mc Henry St. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Harry Ernest Musgrove

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-5566

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine Sullivan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): October 31, 1889

8. AGE: Years 59 | Months 1 | Days 16 | If less than one day: hr. 17 min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER

12. Name: William Musgrove

13. Birthplace: Baltimore, Maryland

MOTHER

14. Maiden Name: Emma Shaffer

15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Katherine Musgrove

(b) Address: 704 Mc Henry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Frederick Rd. Baltimore

18 (a) Funeral director: Charles W. Sachsenhaus

(b) Address: 703 McHenry St.

19 (a) NOV 20 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1948, 3:02 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 17 1948, and that I last saw h alive on Nov 16 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration 2 hrs

Due to: Chronic Cardiovascular disease — 6 yrs

Due to: uric hypertension

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ernest W. Dahm M.D.

Address 732 Poplar Ter Date signed 11/17/48

VS 150

Physicians: please write the causes of death clearly and legibly. Especially important.

MCo. 1-11 1948

HEALTH DEPARTMENT—CITY OF BALTIMORE

G68725

68725

CERTIFICATE OF DEATH

61

1. PLACE OF DEATH 4200 N. Monroe St.

CITY OF BALTIMORE: (No.) Virginia Lee Nursing Home St., (Ward) 8

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Julia Charlotte Cochel

(a) Residence: No. 3345 W. Garrison Ave. St., ... Ward. ...
(Usual place of abode) (If non resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Chester Cochel

6. DATE OF BIRTH (month, day, year) Sept 26, 1878

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	1	22	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ...

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) New York New York

FATHER

13. NAME John Scarabilisch

14. BIRTHPLACE (city or town) (State or country) Trieste Italy

MOTHER

15. MAIDEN NAME Emma Voelmer

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Mr. Charles Cochel
(Address) 4030 Belle ave.

18. BURIAL, CREMATION, OR REMOVAL
Place Druid Ridge Date 11-22 1948

19. UNDERTAKER Wm J. Fickus & Sons
(Address) Balto, Md.

20. FILED NOV 20 1948 Twetington Williams, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov 18 1948

22. I HEREBY CERTIFY, That I attended deceased from Sept 9 1948 to Nov 18 1948
that I last saw h alive on Nov 18 1948 death is said to have occurred on the date stated above, at ... m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	11-7-48
Other contributory causes of importance	
Cystitis & Cystitis	7
Acute Nephritis	0

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ... If so, specify ...

(Signed) Samuel Hueber M. D.

(Address) 611 Preston Bldg

68726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B.

Registered No. G68726

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212 N. Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM PERCY LESTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Blanche Reed Lester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1876

8. AGE: Years	Months	Days	If less than one day
72	4	10	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Credit Dept. - Clerk
11. Industry or business Brager & Eisenberg

FATHER
12. Name Wm. J. Lester
13. Birthplace Engl and

MOTHER
14. Maiden Name Sarah Ann Brooks
15. Birthplace England

16 (a) Informant Mrs. Blanche R. Lester
(b) Address 2212 N. Charles St.

17 (a) Burial (b) Date thereof 11/20/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

NOV 20 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1948 at 1:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1948. to Nov 18 1948.
and that I last saw h IM alive on Nov. 18 1948

Immediate cause of death Carcinoma of Stomach — Duration 5 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J Dawes M. D.
Address 800 W 33rd St Date signed 11-19-48

668727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 668727

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE KAMAITIS

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No. 104-07-2765

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Eva ?
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1887

8. AGE: Years	Months	Days	If less than one day
61	10	11	hr. min.

9. Birthplace: Lithuania (Town, county, and state)
10. Usual Occupation: Carp enter
11. Industry or business

FATHER
12. Name: George Kamaitis
13. Birthplace: Lithuania

MOTHER
14. Maiden Name: Eva ?
15. Birthplace: Lithuania

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov 23-48 (month) (day) (year)
(c) Cemetery or Crematory: National Cem
Location: Rochester N. Y.

18 (a) Funeral director: Joseph Kaminskas
(b) Address: 602 Park Ave

19 (a) NOV 20 1948 (b) Huntington Williams M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 19 48 at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 19 48 to Nov. 18 19 48, and that I last saw h im alive on Nov. 18 19 48.

Immediate cause of death: Chronic lymphatic leukemia — Duration: ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor A. McKusick M. D.
Address U.S. Marine Hosp. Baltimore 11, Md. Date signed 11-18-48

VS 350

668728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 668728

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dulaney Aves
(c) Hospital or institution: West Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 E. Monument Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barracca Jennie BARRACCA

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-0441

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Benedetto V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27 1908

8. AGE: Years	Months	Days	If less than one day
39	10	23	hr. min.

9. Birthplace Gaeta Italy (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Joseph Vacucci
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine Esposito
15. Birthplace Italy

16 (a) Informant B. J. Barracca
(b) Address 2117 E. North Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 22-48 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR Rd. BALTIMORE

18 (a) Funeral director Frank Della Rocca
(b) Address 322 S. High St.

19 (a) NOV 20 1948 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1948 at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to Nov 19 1948.
and that I last saw her alive on Nov 19 1948.

Immediate cause of death 1) Pneumonia, RLL & LUL
Due to 2) Pneumococcal, unidentified, Suppurative bacterial endocarditis
Other Conditions 3) Rheumatic heart disease with mitral stenosis
(Include pregnancy within 3 months of death)

Duration
1 week
(2)
many years

Date of operation
Major findings of operation:
of autopsy Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Warren J. Dare, M.D.
Address Md Bell Gen Hosp Date signed 11-19-48

VS 150

Physicians: please write the causes of death clearly and legibly.

68723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104

Registered No. 68729

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 Binder Court.
(c) Hospital or institution:
Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Binder court.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ester Belle Hicks
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married

6 (b) Name of husband or wife Eddie Hicks 38yrs.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1915

8. AGE: Years	Months	Days	If less than one day
32	11	19 21	— hr. — min.

9. Birthplace Campbell County, VA.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Abraham Martin
13. Birthplace Campbell County, VA.

MOTHER
14. Maiden Name Roxie Anna Shepperson
15. Birthplace Campbell County, VA.

16 (a) Informant Rose Anna Hall (sister)
(b) Address 30 533 N. E. Wash. D.C.

17 (a) Burial (b) Date thereof 11-21-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lynchburg Va.
Location
18 (a) Funeral director A. Adelstein
(b) Address 918 [illegible]
19 (a) [illegible] (b)
(Signature of person in charge of burial) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19, 1948, at 3:30 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 11-6 1948 to 11-19 1948.
and that I last saw her alive on 11-17, 1948.
Immediate cause of death Pneumonia
Due to
Due to
Other Conditions Rheumatic Fever
Avitaminosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature James E. L. Mole, M.D.
Address 303 Bridgeview Pl. Date signed 11/19/48

VS 180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 68730

68730

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1608 W. Mulberry St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1608 W. Mulberry St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Edward Phillips.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	C	Widower

6 (b) Name of husband or wife Mary Jane Phillips

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) November 5, 1868.

8. AGE: Years	Months	Days	If less than one day hr.	min.
80	-	11		

9. Birthplace Kent County Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name James Phillips

13. Birthplace Kent County Md.

MOTHER 14. Maiden Name Annie Ringgold

15. Birthplace Md

16 (a) Informant Herbert Phillips.

(b) Address 1126 Druid Ave. Atlantic N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20, 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 Schroeder St

19 (a) NOV 20 1948 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1948 to Nov 16 1948 and that I last saw h[illegible] alive on 11/7/1948

Immediate cause of death	Duration
Myocarditis	[illegible]
Due to Arteriosclerosis	
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Walter J Lorton

Address 1013 Edmondson Ave Date signed 11/18/48 M. D.

VS 150

668731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. 668731

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 W. Hill St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 W. Hill St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) **FULL NAME** Gladys E. Jackson. ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 29, 1917.

8. AGE: Years	Months	Days	If less than one day
31	7	19	hr. min.

9. Birthplace Cambridge, Md.
(Town, county and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Sneed Ward.
13. Birthplace Md.

MOTHER
14. Maiden Name Maria
15. Birthplace Md.

16 (a) Informant Edna Burrell.
(b) Address 107 W. Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 21, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Longwood St.

19 (a) NOV 20 1948 (b) Huntington Williams, Inc.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1948. at 7:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 4 1948 Nov. 17 1948
and that I last saw her alive on Nov 17 1948

Immediate cause of death

(a) Acute Bronchopneumonia, Duration 2 wks.
Due to
(b) Influenza 3 wks.
Due to
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signed Lincoln Kelly M.D.
Address 908 S. Bway Date signed 11/19/48

X

VS 199

668732

668732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1647 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1647 E Madison St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Roy Kenny

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife Rosie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/12/1901

8. AGE: Years	Months	Days	If less than one day
47	3	6	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Leroy Kenny
13. Birthplace Buckingham Co Va.

MOTHER
14. Maiden Name Margaret Kenny
15. Birthplace Buckingham Co Va.

16 (a) Informant Leroy Kenny
(b) Address 1510 Division St.

17 (a) Removal (b) Date thereof Nov. 20/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Buckingham Co Va.

18 (a) Funeral director Mrs. Ethel A. Elliott
(b) Address 1129 N. Carrollton

NOV 21 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18th 1948, at 4.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2d 1948, to Nov 18th 1948, and that I last saw h[illegible] alive on Nov 18th 1948.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allen A. Johnson M.D.
Address 222 W. Bond St Date signed 11/19/48

VS 3

668733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 668733

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2119 Pine Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 Pine Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James William Hines

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-05-8865

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Annabelle Hines

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) May 17, 1884

8. AGE: Years	Months	Days	If less than one day
64	6	1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Hat Blocker

11. Industry or business Brigham - Hopkins

FATHER 12. Name John Joseph Hines

13. Birthplace Maryland

MOTHER 14. Maiden Name Catherine Feeney

15. Birthplace Maryland

16 (a) Informant Annabelle L. Hines

(b) Address 2119 Pine Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director George J. Schwab

(b) Address 1911 Madison Ave.

19 (a) NOV 21 1948 (Date rec'd by registrar) (b) Evelington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1948, at 9:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/47 1947, to 11/18 1948, and that I last saw him alive on 11/18 1948.

Immediate cause of death: Carcinoma of Stomach

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. P. Fulton III

Address 1947 N. Calvert St. Date signed 11/18/48 M

VS 150

G68734

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68734 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 146 S. London Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 70
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 146 S. London Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME Wilhelmina (Minnie) Beverley Blomeier — (Blomeier)

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife William Blomeier
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Oct. 20, 1862
8. AGE: Years 86 | Months — | Days 30 | If less than one day hr. min.
9. Birthplace Catonsville, Balto. County, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name John Preissinger
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Ruff
15 Birthplace Germany

16 (a) Informant Carl F. T. Blomeier
(b) Address 146 S. London Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-48 (month) (day) (year)
(c) Cemetery or crematory Salem Lutheran
Location Catonsville, Md.
18 (a) Funeral director Geo. L. Schwab
(b) Address 201 Frederick Ave. Baltimore, Md.
19 (a) (Registrar's signature) (b) NOV 21 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1948, at 12:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1930 to Nov 19, 1948 and that I last saw h[illegible] alive on Nov 17 1948.

Immediate cause of death Coronary Occlusion — Duration Sudden
Due to Cardio-Vascular Disease & Decompensation — 1 yr.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Elias W. Johnson
Address 3652 Frederick Ave Date signed 11-24-48

Cord of Woman X

VS 150

G68735

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68735
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2511 W. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 70
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2511 W. Lombard St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edwin Gainor

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charlotte R. Gainor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1877

8. AGE: Years 70 | Months 11 | Days 3 | If less than one day: 24 hr. min.

9. Birthplace Wilmington, Delaware
(Town, county, and state)
10. Usual Occupation City Employee
11. Industry or business Retired

FATHER
12. Name Edwin T. Gainor
13. Birthplace Virginia

MOTHER
14. Maiden Name Emma Hedderick
15. Birthplace

16 (a) Informant Charlotte R. Gainor
(b) Address 2511 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Geo. T. Schwab
(b) Address 2101 Frederick Ave.

19 (a) NOV 21 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1948, at 12:02 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 19 48 to Nov 19 19 48. and that I last saw h[illegible] alive on Nov 18 1948.

Immediate cause of death: Coma of Vascular Hemorrhage
Due to: Arteriosclerotic C.V. disease
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 24 hrs

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify which place)
(e) Means of injury

23. Signature G. P. [illegible] 2425 W. 63rd St.
Address 11/19/48 Date signed

VS 150

668736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 66736

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4322 Glenmore Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4322 Glenmore Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fredericka M. Schuster

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George M.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 28 - 1869

8. AGE: Years: 79 | Months: - | Days: 21 | If less than one day: hr. min.

9. Birthplace: Balto. (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER 12. Name: Adam J. Walter
13. Birthplace: Balto.

MOTHER 14. Maiden Name: Sophia Hammel
15. Birthplace: Balto.

16 (a) Informant: Loretta Muhlmeister
(b) Address: 4322 Glenmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 22 48 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross
Location: Brooklyn

18 (a) Funeral director: Riggel Bros.
(b) Address: 710 Belair Rd.

19 (a) NOV 21 1948 (b) Signature of local registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 19 1948 at 10:39 A.M.

21. I certify that death occurred on the date above-stated; that I attended deceased from Sept. 9 1948 to Nov. 19 1948. and that I last saw h-r alive on Nov. 18 1948.

	Duration
Immediate cause of death: Metastatic Carcinoma of Lungs	2 mos.
Due to: Papilloma of Bladder	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation: May 13 - 1946

Major findings of operation: Papilloma of bladder - Metastatic epidermoid carcinoma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) (While at work)
(e) Means of injury

23. Signature: Wm D Johnston
Address: 701 N. Linwood Ave.
Date signed: 11/19/48
M. D.

668737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

668737 ?

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6300 Pinehurst Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James W. Carpenter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Mar

6 (b) Name of husband or wife Frances Ciarrocca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/3/08

8. AGE: Years	Months	Days	If less than one day
40	5	15	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Journalist
11. Industry or business

FATHER
12. Name Herbert L. Carpenter
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth B. Clarke
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Frances G. Carpenter
(b) Address 6300 Pinehurst Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. H. Tilghman and Son
(b) Address 805 N. Calvert St.

19 (a) 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18 1948, at 9:55 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/10 1948 to 11/18 1948, and that I last saw h[illegible] alive on 11/18 1948.

Immediate cause of death Acute Hemorrhagic pancreatitis — Duration

Due to Acute Pancreatitis

Due to Coronary Thrombosis

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Blazer M. D.
Address Date signed 11/20/48

VS 150

118

668738

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6687 (?)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2250 SIDNEY AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (30)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2250 SIDNEY AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MYRTLE ELSIE RIDDLE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife GILBERT O. RIDDLE

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) JULY 21, 1888

8. AGE: Years 60 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace EASTON, Md.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name SOLOMON COVEY
13. Birthplace EASTON, Md.

MOTHER
14. Maiden Name MARY CATHARINE (?)
15. Birthplace EASTON, Md

16 (a) Informant GILBERT O. RIDDLE
(b) Address 2250 SIDNEY AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 22 NOV. 1948 (month) (day) (year)
(c) Cemetery or crematory M.E. CHURCH CEM
Location EASTON, Md.

18 (a) Funeral director Walter Boyle Bradley
(b) Address 1922 W. North Avenue
(c) 1948 Temporarily Williams, M.D.
(Date rec'd by registrar) Registrar

NOV 22

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1948 at 4 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1948 to Nov. 20 1948 and that I last saw her alive on Nov. 20 1948

Immediate cause of death
Myocarditis
Due to Hypertension
Acute Bronchitis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
3 yrs
4 hrs
1 wk.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry F. Coates
Address 517 Scott St Date signed 11/30/48

VS 150

G68739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G68739 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 E. Lorraine Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LENA GERSHOWITZ

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Abraham | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1875

8. AGE: Years 72 | Months | Days | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Not Known

13. Birthplace Germany

MOTHER

14. Maiden Name Not Known

15. Birthplace Germany

16 (a) Informant Mrs Helen Boak

(b) Address 308 E Lorraine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-48 (month) (day) (year)

(c) Cemetery or crematory Loudale

Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Jr

(b) Address 200 Eutaw Place

19 NOV 21 1948 (Date rec'd by registrar) Huntington Williams, M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1948 at 4 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1948 to Nov 19 1948. and that I last saw her alive on Nov 19 1948

Immediate cause of death RESPIRATORY FAILURE + TOXEMIA — Duration

Due to CARCINOMA OF GALLBLADDER & DUCTS & TOXEMIA.

Due to

Other Conditions OBSTRUCTIVE JAUNDICE DUE TO CA.
(Include pregnancy within 3 months of death)

Date of operation Nov. 11, 1948

Major findings of operation: INOPERABLE CARCINOMA OF BILIARY SYSTEM

of autopsy: Ca of GALLBLADDER + DUCTS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Merle S. Schers, M.D. M. D.

Address Sinai HOSPITAL Date signed 11-19-48

G68740

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G68740 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 W Franklin
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 W Franklin (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZEBETH B. MENDELIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Joseph F. Mendelis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~Oct 29 1873~~ May 29 1873 If less than one day hr. min.

8. AGE: Years 73 | Months 5 | Days 21

9. Birthplace Lithuania (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Fraik Pocius

FATHER 13. Birthplace Lithuania

MOTHER 14. Maiden Name Urbanovich

MOTHER 15. Birthplace

16 (a) Informant Bert Mendelis

(b) Address 114 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22 48 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Charles W Faehrmann

(b) Address 703 McHenry St.

19 (a) Nov 22 1948 (Signature of registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1948, at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946, to Nov 19 1948, and that I last saw her alive on Nov 19 1948.

Immediate cause of death	Duration
Pulmonary Embolism	7 hrs
Due to Auricular Fibrillation	24 hrs
Due to Coronary Heart Disease	10 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. J. Mendelis M. D.
Address 651 N Fremont Date signed 11-19-48

VS 150

Physicians: Please write the causes of death clearly and legibly. Any necessary supplementary information may be added.

G68741
JL - 119714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

G68741 ✓
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 W. Redwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur Mason (Wilbert Mason)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 26, 1881

8. AGE: Years	Months	Days	If less than one day
67	1	16	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Hall
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/48 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Loudon Park Rd

18 (a) Funeral director Fahey Funeral Home
(b) Address 3128 Eighth St.

19 (a) 1948 Huntington Williams, M.D.
(Signature of local registrar)
NOV 23
VS 150

MEDICAL CERTIFICATION

AM

20. DATE OF DEATH Nov. 12 1948, at 4.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1948, to Nov. 12 1948, and that I last saw him alive on Nov. 12 1948.

Immediate cause of death — Duration
Pulmonary Edema — hour
Due to Pulmonary Cancer, Secondary disease Spine — Two
Due to
Other Conditions Cirrhosis & Pneumonia
(Include pregnancy within 3 months of death)
Date of operation 6/10/48, 1/23/48
Major findings of operation: Exploratory
Biopsy Pulmonary tumor
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward [illegible] M.D.
M. D.
Address [illegible] Date signed 11/21/48

99

G68742 ✓ G68742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

Registered No.

G68742

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2557 McCulloh st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jane Henry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Josiah Henry
6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr) 1-15-79

8. AGE: Years	Months	Days	If less than one day
69	10	18	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lloyd Wheatley
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Keene
15. Birthplace Md.

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-48 (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Cambridge Md.

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address: 1211 N. Arlington Ave

19 (a) 11-21-1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at 7.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12 1948 to 11-19 1948, and that I last saw h~~e~~r alive on 11-19 1948.

Immediate cause of death	Duration
Cerebrovascular accident	
Due to cerebral embolism EMBOLUS	
Due to Auricular fibrillation AURICULAR	
Other Conditions,	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature John Caldwell Torrey M. D.
Address Johns Hopkins Date signed 11-20-48

VS 150

668743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. 668743

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521- Camel Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521- Camel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Belle Ridgley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 1866

8. AGE: Years 82 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Billie Ridgley
13. Birthplace Va.

MOTHER
14. Maiden Name Isabelle ?
15. Birthplace Va.

16 (a) Informant Joe Ridgley
(b) Address 800- Brooks Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 20 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Mt. Calvary

18 (a) Funeral director A. Holstead
(b) Address 918- Reid St

19 (a) (Date received by registrar) Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18/1948 at 12 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10/1948 to 11/18/1948 and that I last saw him alive on 11/16/1948

Immediate cause of death: Chronic Myocarditis — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Ridgley, M. D.
Address 450 W. Biddle St. Date signed 11/20/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

USN Vs 183

G68744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G68744 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Ellwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Ellwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STANISLAUS JEDRZEJCZAK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1870

8. AGE: Years	Months	Days	If less than one day
78	5	23	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Jacob Jedrzejczak
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informan: Peter Jedrzejczak (son)
(b) Address 1212 Ellwood Avenue

17 (a) Burial (b) Date thereof 11/22/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave

18 (a) Funeral director Lilly & Zeile Inc
(b) Address 403 S. Broadway

21 1948 (a) 11 22 1948 (b)
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1948, at 9.20a M

21. I certify that I took charge of the remains described above, held an Inspec. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Weaver M.D.
Medical Examiner.
Date signed November 18, 1948

G68745

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68745 61 Registered No. G68745

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2243 E. Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lin Der

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Yellow	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-18-01

8. AGE: Years	Months	Days	If less than one day
47	-	29	hr. min.

9. Birthplace Calif. (Town, county, and state)
10. Usual Occupation Laundryman
11. Industry or business

FATHER
12. Name Jum Der
13. Birthplace China

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location [illegible]

18 (a) Funeral director [illegible]
(b) Address [illegible]

NOV 21 1948 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1948, at 6 50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1948, to 11-16 1948, and that I last saw him alive on 11-16 1948.

Immediate cause of death Hepatic coma — Duration

Due to Hepatic insufficiency - acute severe

Due to ? Laennec Cirrhosis

Other Conditions Diabetes mellitus - mild.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address The Johns Hopkins Hosp. Date signed 11/17/48 M. D.

VS 150

124a

G68746 B.C. 48-1998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G687466 Registered No. 111c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2244 LINDEN AVE.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2244 LINDEN AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARILYN HARRISON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 15, 1948

8. AGE: Years	Months	Days	If less than one day
	2	5	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation
11. Industry or business NONE

FATHER
12. Name SOLOMON HARRISON
13. Birthplace NEW YORK CITY

MOTHER
14. Maiden Name RUTH POMERANTZ
15. Birthplace BALTIMORE MD

16 (a) Informant: ALVIN POMERANTZ
(b) Address 2244 LINDEN AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 21, 1948 (month) (day) (year)
(c) Cemetery or crematory MISHKIN ISRAEL CEM.
Location SOUTHERN AVE.

18 (a) Funeral director SOL LEVINSON & BROS
(b) Address 1124-26 W. NORTH AVE.

18 (c) NOV 21 1948 (Date rec'd by registrar) (d) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 20 1948, at 4:20 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed 21 Nov 48

VS 151

G68747 B.C. 48-21864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182a

✓ G68747 47 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2418 Oswego Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jerry Handleman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10/14/48
8. AGE: Years | Months 1 | Days 7 | If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business None
FATHER 12. Name Norman Handleman
13. Birthplace Baltimore Md.
MOTHER 14. Maiden Name Leatrice Hoffman
15. Birthplace Baltimore Md.
16 (a) Informant:
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Shaarei Tfiloh Cem
Location Windsor Mill Rd.
18 (a) Funeral director Joseph Levy & Son
(b) Address 210 Lexington Place
19 NOV 21 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1948, at 7 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Mechanical Suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15 11 48
(a) Date of injury 21 Nov 48 at 7 A.M.
(b) Where did injury occur? 2418 Oswego Ave
(c) Did injury occur at home, on farm, industrial place or public place? Home While at work? No
(d) Means of injury Smothered by Crib Bumper

23. Signature [signature] M.D. Medical Examiner
Date signed 21 NOV 48

VS 151

G68748

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68748 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Hartman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widow.

6 (b) Name of husband or wife Frank Hartman
6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr Oct 18, 1875

8. AGE: Years	Months	Days	If less than one day
about 73	1	1	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Starr Wheeler
(b) Address 3712 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22/48 (month) (day) (year)
(c) Cemetery or crematory Mt Cathedral
Location Old Frederick Road.

18 (a) Funeral director Austin E. Donovan.
(b) Address 3638 Roland Ave.

19 (a) 1948 (b) [illegible] (Date rec'd by Registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1948 at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15, 1948 to Nov. 19, 1948. and that I last saw her alive on Nov. 19, 1948.

Immediate cause of death Lobar pneumonia, ~~left~~ both lobes
Duration 7 days.
Due to
Due to
Other Conditions Arteriosclerotic Cirrhosis, Chronic hepatitis; chronic nephritis
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy See Cause of death

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. C. Insley, Jr. M. D.
Address 1213 Light Street Date signed 11/19/48

668749

BC-48-2528

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

668749
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
27-17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2718 Spaulding Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Weiner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
0	—	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Philip Weiner
13. Birthplace New York.

MOTHER
14. Maiden Name Jean Peltz
15. Birthplace New York

16 (a) Informant Philip Weiner
(b) Address 2718 Spaulding Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21 48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Comfort
Location Germany Hill Rd.

18 (a) Funeral director Jack Levine
(b) Address 2100 Eutaw Pl.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 21 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21-48 19 at 6 45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-19-1948, to 11-21-1948 and that I last saw him alive on 11-21-1948.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Aspiration	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Weiss, M. D.
Address Sinai Hospital Date signed 11/21/48

107

68750 4P-24759 BALTIMORE CITY HEALTH DEPARTMENT X ✓ 68750
CERTIFICATE OF DEATH 159E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1645 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Leftwich

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 8 | If less than one day: hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Douglas A. Leftwich
13. Birthplace Va.

MOTHER 14. Maiden Name Anita Rhodes
15. Birthplace Va

16 (a) Informant Mrs. D. A. Leftwich
(b) Address 1645 Eastern Ave.

17 (a) Removal (b) Date thereof Nov. 22-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Fairport, Va

18 (a) Funeral director John E. Connolly
(b) Address 48 Eastern Ave.

19 (a) Nov 22 1948 (b) Hunter or Williams, M.D.
(Date received by Local Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21-1948, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14-1948 to 11-21-1948, and that I last saw him alive on 11-21-1948

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia Intermittent capital defect

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Weiss
Address Sinai Hospital Date signed 11/22/48

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

Registered No. 68751

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen'l Hosp. 28-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5605 Wayne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marvin Davis, Sr.

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife: Emmie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1884

8. AGE: Years	Months	Days	If less than one day
64	5	1	hr. min.

9. Birthplace: Darlington S. Car. (Town, county, and state)
10. Usual Occupation: Restaurant
11. Industry or business: Owner

FATHER
12. Name: John C. Davis
13. Birthplace: S.C.

MOTHER
14. Maiden Name: Henrietta Patrick
15. Birthplace: S.C.

16 (a) Informant: Mrs. Emmie Davis
(b) Address: 5605 Wayne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul Street

19 (a) NOV 22 1944 (Date rec'd by registrar) (b) [illegible] for William M. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1944, at 4 00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 18 1944 to Nov 20 1944, and that I last saw h[illegible] alive on Nov 20 1944.

Immediate cause of death: Cardiovascular Renal disease (uremia) — Duration: 1 week

Due to: Arteriosclerosis ? ?
Due to: Hypertensive cardiovascular disease with cardiac hypertrophy ?

Other Conditions: Aneurysm of Abdominal Aorta Arteriosclerosis and glaucoma

Date of operation (Give month, day, and year of each)

Major findings of operation:

of autopsy: above

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Marvin W. Davis M. D.
Address: West Balto Gen'l Hosp Date signed: 11-20-44

VS 150

13 1a

6687:52

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

48 B

6687:52
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4848 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4848 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA M. LEWIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Richard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1875

8. AGE: Years	Months	Days	If less than one day
73	3	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business ---66666666-----

FATHER
12. Name Lawrence Wappman
13. Birthplace Md

MOTHER
14. Maiden Name M. Veters
15. Birthplace Md

16 (a) Informant Richard Lewis
(b) Address 4848 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 NOV 22 1948 Name rec'd by registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1948 19 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 19 48 to Nov 20 19 48 and that I last saw h alive on Nov 20 19 48

Immediate cause of death Carcinoma of uterus — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Manuel Levin M.D.
Address 4848 Reisterstown Rd Date signed Nov 20/48

VS 15.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 S. Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MRS CLARA FRANCIS

3 (b) If veteran, name war: W
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife: Peter E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 14/1876

8. AGE: Years	Months	Days	If less than one day
72	9	6	hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: William Gotteimier
13. Birthplace: Germany

MOTHER
14. Maiden Name: Christine Folkam
15. Birthplace: Germany

16 (a) Informant: Peter E. Francis
(b) Address: 507 S. Ellwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)
(c) Cemetery or crematory: Oaklawn
Location: Baltimore, Maryland

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul Street

19 NOV 22 1948 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 NOV 1948 at 1.00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 01 NOV 1948 to 20 NOV 1948. and that I last saw HER alive on 20 NOV 1948.

Immediate cause of death: CARDIAC ARREST — Duration: 1 min

Due to CARDIAC HYPERTROPHY & MYOFIBROSIS — 5-10 YRS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: AUTOPSY.

of autopsy: 1) ABOVE CARDIAC DIAGNOSES 2) DIVERTICULI, ESOPHAGUS & DUODENUM 3) HEMORRHAGIC ENTEROCOLITIS

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Donald T. England M. D.
Address: Maryland Gen Hosp (Date signed) 22 Nov 48

PHYSICIAN
Underline the cause to which death should be charged statistically

VS 190

6687:54

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95R

6687:54
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. + Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 St. Paul St. (If rural, give location)
(e) Citizen of foreign country? No. Yes or No
If yes, name country

3 (a) FULL NAME Mr. Thomas Julius Mohr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs. Mabel My Mohr
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 25, 1902
8. AGE: Years 46 | Months 9 8 | Days 18 22 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Musician
11. Industry or business

FATHER
12. Name Mr. John Mohr
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Willie Waithman
15. Birthplace ~~Baltimore, Md.~~ Virginia

16 (a) Informant Wife
(b) Address 2023 St. Paul St., Balt.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.
18 (a) Funeral director Wilhelm & Corpe
(b) Address 2114 St. Paul St.
19 NOV 22 1948 (Date rec'd by registrar) (b) for William H. Register

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1948 at 9 M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6, 1948 to Nov 20, 1948. and that I last saw him alive on Nov. 20, 1948.

Immediate cause of death: Rheumatic Heart Disease with Mural Thrombi
Due to Myocardial Failure
Due to Multiple Pulmonary Infarctions
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: By Abm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury
23. Signature J. Frank Supplee, M.D.
Address Union Memorial Hosp Date signed 11/19/48

VS 150

6687:55

CERTIFICATE CORRECTED 9-1-50

BALTIMORE CITY HEALTH DEPARTMENT

ES-124740

CERTIFICATE OF DEATH 124a

6687:55

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 EASTERN AVE.

(c) Hospital or institution: BALTO. CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 302 N. Broadway (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Rosenzweiz or Harry Rosenzweig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Mass. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Abraham Rosenzweiz

13. Birthplace Russia?

MOTHER

14. Maiden Name Ida ?

15. Birthplace Russia?

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS

(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philad Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eastern Ave

19 NOV 22 1948 (Date rec'd by registrar) (b) Irvington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21 1948 at 1:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1948 to 11-21 1948 and that I last saw him alive on 11-21 1948

Immediate cause of death	Duration
Pulmonary edema	3 hrs.
Due to unknown cause	
Due to	
Other Conditions Cirrhosis, Laennec's severe.	1 mo

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William H. Weaker M D

Address Balto City Hosp Date signed Nov 22 48

VS 150

111c

G687556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G687556 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 Da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Springhill Avenue
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Boy Cohen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1948

8. AGE: Years	Months	Days	If less than one day
		26	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Phillip Cohen
13. Birthplace Baltimore

MOTHER
14. Maiden Name Bernice Freedman
15. Birthplace New York

16 (a) Informant
(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 19 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 NOV 22 1948 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1948 19 . at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1948 to Oct 5 1948, and that I last saw h[illegible] alive on Oct 5 1948.

Immediate cause of death Congenital Heart Disease Ruptured Aneurysm

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Ruptured aneurysm

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sydney Altbeker
Address Sinai Hospital Date signed Nov 17/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66857

159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. and Rutland Ave.
(c) Hospital or institution:
Sinai Hospital of Baltimore, Inc.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3Da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 14 Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Taylor Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Jackson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1948

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Jackson
13. Birthplace Baltimore

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Sinai Hosp.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 19 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1948, at 10:20 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to 19 .
and that I last saw h alive on 19 .

Immediate cause of death Prematurity
Hemorrhagic Diseases of Newborn
Anemia due to Chronic Loss of Blood

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature by Lucy G. Warren M.D.
Address Sinai Hospital Date signed Nov 17/48

Please write the causes of death clearly and legibly. Physicians are especially important.

GRv+P-23787

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 68758

CERTIFICATE OF DEATH 160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Avenue
(c) Hospital or institution:
Sinai Hospital of Baltimore, Inc. 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 637 Portland Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Scherr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White W.	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry Scherr
13. Birthplace Russia

MOTHER
14. Maiden Name Rose Belkowitz
15. Birthplace New York

16 (a) Informant Rose Scherr
(b) Address 637 Portland Street

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 19 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Nov 3 1948, and that I last saw h/ liv alive on Nov 3 1948.

Immediate cause of death	Duration
Subarachnoid Hemorrhage + Prematurity	
Due to	
Due to	
Other Conditions Atelectasis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan J. Wolmaker M. D.
Address Sinai Hosp Date signed 11/17/48

VS 155

X

6687:9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. 6687:9

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2731 Eastern Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2731 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret (Maggie) Stallings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Samuel Stallings
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1871

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

MOTHER'S MAIDEN
12. Name Christian Timm
13. Birthplace

14. Maiden Name Margaret Haugh
15. Birthplace

16. (a) Informant John Weifenbach
(b) Address 443 N. Robinson St.

17 (a) Burial (b) Date thereof Nov 22/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loraine Cem
Location Balto

18 (a) Funeral director Welch Funeral Home
(b) Address 2007 Orleans St.

19 (a) [illegible] 22 1948 (b) Huntingdon Williams, M.D.
(Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1948 at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1948 to Nov 19 1948, and that I last saw her alive on Nov. 19 1948.

Immediate cause of death	Duration
Carcinoma of Uterus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Zellers, M.D.
M. D.
Address 2739 Eastern Ave. Date signed 11/29/48.

VS 150

68760 Hospital Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 68760

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 N. Carey, (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby-girl Harley

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col.	

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) 11/20/48

8. AGE: Years | Months | Days | If less than one day: 3 hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Oscar Harley
13. Birthplace N. C.

MOTHER
14. Maiden Name Catherine Davis
15. Birthplace Md.

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory .....
Location .....

18 (a) Funeral director .....
(b) Address .....

19 NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1948, at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19..., and that I last saw h... alive on ..... 19...

Immediate cause of death ..... Duration

Prematurity

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature A. C. Lang, M. D.
Address Johns Hopkins Hosp Date signed 11-20-48

VS 150

M. D. D. 1928-9

G6870.1 ✓ G6870.1

G6870.1 HEALTH DEPARTMENT—CITY OF BALTIMORE

BC-48-2463

CERTIFICATE OF DEATH 159

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4224 6th St - St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Baby Girl Williams - -

(a) Residence: No. 4224 - 6th St - St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Wh.	- -

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Nov. 14, 1948

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

FATHER

13. NAME William Robert Williams

14. BIRTHPLACE (city or town) Lieto. ...
(State or country)

MOTHER

15. MAIDEN NAME Mary Louise Burt

16. BIRTHPLACE (city or town) Huntington, W. Va.
(State or country)

17. INFORMANT Mrs. Mary L. Williams

(Address) 4224 - 6th St

18. BURIAL, CREMATION, OR REMOVAL

Place [redacted] NOV 16 1948 19

19. UNDERTAKER Commissioner of Health

(Address)

20. FILED NOV 22 1948 Huntington, Williams, M... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov. 14 ... 1948

22. I HEREBY CERTIFY, That I attended deceased from 11/14 ... 1948 to 11/14 ... 1948

I last saw her alive on 11/14 ... 19 48 Death is said to have occurred on the date stated above, at 3:50 a m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Premature birth	

Other contributory causes of importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19 ...

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?

If so, specify ...

(Signed) [redacted] M. D.

(Address) [redacted]

Instructions on back of certificate.

068762 BC-48-25682

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 160c

✓ 068762 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 32 E. Fort Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy McCormick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 48

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry McCormick
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Margaret Goodwyn
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. McCormick
(b) Address 32 E. Fort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Jenkins & McCann
(b) Address 32 E. Fort Ave.

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address Franklin Square

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1948, at 5:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1948 to 11/21 1948, and that I last saw h/xx alive on 11/21 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Anoxia of brain.	
Due to Breech Extraction & Shock	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Watts K. Shelsley M. D.
Address Franklin Square Date signed 11/24/48

VS 580

68763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

Registered No. 66870

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: HENRY PETERSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife: Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation Unknown
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant: Unknown
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 15 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 22 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1948, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Strangulation
Other Conditions Chronic Alcoholism
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or secondary ☐ cause of death, fill in the following:
(a) Date of injury Nov. 8, 48 ? M.
(b) Where did injury occur? 2806 N. Calvert St.
(c) Did injury occur at home, on farm, in factory, in place of public place? Home While at work? No
(d) Means of injury Hung self with rope on bed-

23. Signature John L. Daus M.D.
Medical Examiner
Date signed 11/8/48

68764

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

178a

Registered No. 66870

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18-
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 West Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE SPROLES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of Husband or wife Beulah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
39			hr. min.

9. Birthplace U (Town, county, and state)
10. Usual Occupation N
11. Industry or business N

FATHER
12. Name N
13. Birthplace U

MOTHER
14. Maiden Name N
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 15 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 12 1948 (b) Christopher Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1948 at 6.25 PM

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to carbon monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-9-48 at 1411 M.
(b) Where did injury occur? 807 W. Fayette St.
(c) Did injury occur at home, on farm, industrial place, in pub place? home While at work? no
(d) Means of injury Open in adjoining room on but unlit

23. Signature Earl L. Kopp M.D.
Medical Examiner.
Date signed November 10, 1948

68765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. 68765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 19 +
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 St. Barnabas St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Chauncey Hughes.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife none
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) 1902

8. AGE: Years	Months	Days	If less than one day hr	min
46				

9. Birthplace Baltimore ?
(Town, county, and state)
10. Usual Occupation Junk Collector.
11. Industry or business

FATHER 12. Name William Hughes.
13. Birthplace Md.

MOTHER 14. Maiden Name Fanny Smith
15. Birthplace Md.

16 (a) Informant Chauncey Hughes
(b) Address 912 St. Barnabas St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 16 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Livingston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10-48 19 at 3:47 P M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10-25 1948, to 11-10 1948, and that I last saw h[illegible] alive on 11-10 1948.

Immediate cause of death Respiratory failure — Duration

Due to Postal Exhaustion

Due to Chronic alcoholism Malnutrition

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert R. Hahn M. D.
Address University Hosp Date signed 11-12-48

G6870 6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G6870 6

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2704 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Northern PKwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Francis Cook
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-20-5994

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	WIDOWED

6 (b) Name of husband or wife OTillie K.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov-16-1883

8. AGE: Years	Months	Days	If less than one day
65	0	3	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name John J. Cook
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Rodgers
15. Birthplace Md.

16 (a) Informant Mrs. MILDRED Brady
(b) Address 2704 Northern PKwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location BALTo

18 (a) Funeral director L. J. Ruck
(b) Address 5[illegible] HARTford Road-

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Thurstington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 .
and that I last saw him alive on January 1948.

Immediate cause of death Coronary occlusion — Duration

Due to arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Donald Landon M. D.
Address 4077 Hayward Rd Date signed 11-19-48

VS 150

Physician's especially important duty. Physicians: please write the causes of death clearly and legibly.

G68767 Bacon

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G68767

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1503 Holbrook Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Holbrook Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hildagard (Hilda) Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife August Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 17, 1870

8. AGE:	Years	Months	Days	If less than one day
	78	3	3	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Pious Gutmann
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Ann T. Schmidt
(b) Address 1503 Holbrook Street

17 (a) Burial (b) Date thereof 11-24-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Nov 22 1948 (b) Thurlington for Williamson, M.D.
(Filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20th 1948 at 6.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to Nov. 20 1948.
and that I last saw h[illegible] alive on Nov. 20 1948.

Immediate cause of death	Duration
Chr. myocarditis & arteriosclerosis and	10 yrs.
Due to hypertension	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A. M. Bacon M. D.
Address 2810 Taylor Ave. Date signed 11/24/48

VS 15

668768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

668768

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2717 Orleans St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Valentine King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or divorced.
Male	White	Married

6 (b) Name of husband or wife Barbara King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30 1858

8. AGE: Years 90 | Months - | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles King
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Virginia Victor
(b) Address 2717 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Morelands Memorial Park
Location Taylor Ave

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington for Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1948 to Nov 20 1948 and that I last saw him alive on Nov 20 1948

Immediate cause of death	Duration
Fecal Obstruction	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Wm J Kinnett M.D.
Address 701 N Lanvale Ave Date signed 11/22/48

VS 150

68769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

✓ 68769 Registered No.

1. PLACE OF DEATH

(a) Baltimore City, Maryland

(b) Street address 533 E. 38th St. Baltimore 18

(c) Hospital or institution: 4-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 533 E. 38th St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME James John Schuch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 7, 1877

8. AGE: Years	Months	Days	If less than one day
71	0	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation watchman

11. Industry or business

FATHER 12. Name Matthias Schuch

13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Wolf

15 Birthplace Germany

16 (a) Informant Joseph F. Schuch (Son)

(b) Address 533 38th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23-48 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary (cem

Location Baltimore County

18 (a) Funeral director John M. Weber

(b) Address 401 S. Chester street

19 (a) [illegible] (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at 3.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1948, to 11-19 1948, and that I last saw him alive on 11-19 1948.

Immediate cause of death: Massive Pulmonary embolism Left

Due to Thrombophlebitis, right leg

Due to

Other Conditions hypertensive cardiovascular disease arteriosclerotic heart disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: pulmonary embolism

Duration	
	5 minutes
	5 weeks
	years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. T. Por 3rd.

Address Union Memorial Hospital Date signed 11-19-48

VS 150

100 C

68770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9-D

Registered No. 68770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 Forrest St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (Mrs.) Mamie Jackson
3 (b) If veteran, name war /
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Albert
6 (c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) 4-6-98
8. AGE: Years 50 | Months 7 | Days 12 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name ? Cooper
13. Birthplace ?

MOTHER
14. Maiden Name Mary Robinson
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Ag. Co. Md.
18 (a) Funeral director Robert E. Williams
(b) Address 1545 McElderry
19 NOV 22 1948 (Date rec'd by registrar) Registrar Washington Williams M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1948, at 9:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1948, to 11/18 1948 and that I last saw h alive on 11/18 1948.

Immediate cause of death	Duration
Cerebral thrombosis	
Due to: Hypertensive cardiovascular disease	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Campbell Harvey M.D.
Address Johns Hopkins Hospital Date signed 11-18-48

X

G68771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. G68771

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St.
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Raspeburg, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5819 McCormick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER N. McCORMICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Emily C. McCormick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11th, 1882

8. AGE: Years	Months	Days	If less than one day
66	10	10	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Holy Redeemer

FATHER
12. Name Charles McCormick
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Ella Lambright
15. Birthplace Harford County, Md.

16 (a) Informant Mrs. Carl B. Sprecher, Jr.
(b) Address 1118 Orems Road, Balto., 20

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Leasahs Funeral Home
(b) Address 7401 Belair Rd.

NOV 22 1948 (Date received by registrar) (b) Filed Washington Millis M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 21 1948 at 3:44 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1) 2/1948 to 21 Mar 19 .
and that I last saw h[illegible] alive on 21 Mar 1948.

Immediate cause of death	Duration
a Uremia	
Due to Hypertension Arteriosclerotic Renal Disease	
Due to Hypertension	
Other Conditions Hypertrophy Prostate	
a Acute Urinary retention (Include pregnancy within 3 months of death)	
Date of operation 11/11/48	
Major findings of operation: Prostatic Hypertrophy	
of autopsy: Arteriosclerotic Renal Disease	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael F. Cavanaugh M.D.
Address 7616 Ney Ave Date signed 11/20/48

8772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4210 Sarmont
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4210 Piedmont Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Johnson

3 (b) If veteran, name war no

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Florence A Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1875

8. AGE: Years	Months	Days	If less than one day
73	8	15	hr. min.

9. Birthplace Norway
(Town, county, and state)

10. Usual Occupation Carpenter Retired

11. Industry or business P. R. R.

FATHER
12. Name ? Johnson
13. Birthplace Norway

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Laura B. Johnson
(b) Address 4210 Paramount Ave

17 (a) Burial (b) Date thereof Nov 22 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Mem
Location Taylor Ave

18 (a) Funeral director John A. Miller
(b) Address 2224 Pennsylvania Ave

19 (a) NOV 22 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1948, at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1948 to Nov 19 1948, and that I last saw him alive on Nov 18 1948.

Immediate cause of death	Duration
Bronchopneumonia	9 d
Uraemia	5 d
Due to Mitral Regurgitation	1 mo
Incompetence	
Due to Chronic Interstitial Nephritis	1 mo
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. F. A. Stevens M. D.
Address 2878 Harford Ave Date signed 11 19 48

V S 150

G68773 KARL

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No. G68773

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway at Fairmont
(c) Hospital or institution: Church Home + Hospital Inc.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 W. Lombard (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Karl Gunnen Leino

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of former wife Mrs. Hilja Leino
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/24/87

8. AGE: Years	Months	Days	If less than one day
61	9	26	hr. min.

9. Birthplace Finland (Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business

FATHER
12. Name Karl Ekstron
13. Birthplace Finland

MOTHER
14. Maiden Name Ida Halmroos
15. Birthplace Finland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.
18 (a) Funeral director Roland L. Fisher
(b) Address 1432 Dundalk Ave.
19 (a) NOV 22 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20/48 19 , at 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12 1948, to 11-20 1948, and that I last saw h/ alive on 11-19 1948.

Immediate cause of death	Duration
Generalized Peritonitis	3 days
Due to Leaking Pneumonia	
Due to	
Other Conditions Pulmonary atelectasis + edema (Include pregnancy within 3 months of death)	

Date of operation 11/16/48
Major findings of operation: Carcinoma 9 stomach
of autopsy: Generalized Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature T. T. Morrow M. D.
Address Church Home Hosp. Date signed 11-20-48

VS 150

G68774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G68774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Park Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-2
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Park Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Ann Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 13, 1868

8. AGE: Years	Months	Days	If less than one day
80	--	6	hr. min.

9. Birthplace California (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Roberts
13. Birthplace Wales

MOTHER
14. Maiden Name Elizabeth Griffiths
15. Birthplace Wales

16 (a) Informant Mr. J. F. Thrift
(b) Address 2809 W. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) NOV 22 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS (59)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to 11/18 1948, and that I last saw h[illegible] alive on 11/4 1948.

Immediate cause of death: Paralysis flaccid due to metastatic carcinoma. — Duration: 3 weeks.
Due to: Carcinoma ileum r/o ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation 2/11/48.
Major findings of operation: Biopsy - non diagnostic.
of autopsy: 11/20/48 - partial.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry F. Lauer, M. D.
Address Medical Arts Bldg. Date signed

For Henry F. Lauer X

668775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668775 Registered No. 122a

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or ~~INSTITUTION~~ St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 E. Biddle (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Mary Kinzer

3 (b) If veteran, name war ----
3 (c) Social Security Account No. -----

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Albert J. Kinzer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) May 29, 1883
8. AGE: Years 65 | Months 6 | Days 1 | If less than one day ... hr. ... min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frisby Lloyd
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Lynch
15. Birthplace Unknown

16 (a) Informant Miss Margaret Kinzer
(b) Address 2407 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Arrington
(b) Address 2024 Orleans St.

19 NOV 22 1948 (Date rec'd by registrar) Thurlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1948, at 5:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24, 1948 to Nov. 21, 1948, and that I last saw her alive on Nov. 21, 1948

Immediate cause of death	Duration
Hypostatic Pneumonia.	
Due to Chronic Peritonitis	
Due to Incarcerated Hernia. & dehiscence of Repair	
Other Conditions Hypertensive C.V.D.	

(Include pregnancy within 3 months of death)

Date of operation 10/26/48
Major findings of operation: Incarcerated. Ventral hernia & Umbilical Hernia
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature John T. Everett M.D.
Address St. Joseph's Hosp. Date signed 11/24/48

VS 189

68776

HEALTH DEPARTMENT—CITY OF BALTIMORE

68776

CERTIFICATE OF DEATH

93

1. PLACE OF DEATH

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1402 N. Linwood Ave Ward)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... da. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... da.

2. FULL NAME Wm. A. Bell

If U. S. Veteran specify WAR .....

(a) Residence: No. 1423 N. Montford Ave St., 8-2 Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Georgie Bell

6. DATE OF BIRTH (month, day, year) April 2nd 1884

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	7	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Md

FATHER

13. NAME Henry Thomas Bell

14. BIRTHPLACE (city or town) (State or country) Md

MOTHER

15. MAIDEN NAME Mary E. Askew

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Benson Waldman

(Address) 4528 Marble Hall Rd

18. BURIAL, CREMATION, OR REMOVAL

Place Cedar Lawn Date Nov 24th 1948

19. UNDERTAKER Leo G. Cook

(Address) 1701-03 N. Patterson Park Ave

20. FILED NOV 22 1948 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) NOVEMBER 21, 1948

22. I HEREBY CERTIFY, That I attended deceased from JULY, 1948 to NOVEMBER, 1948

I last saw h.i.m. alive on NOVEMBER 14 1948. Death is said to have occurred on the date stated above, at 6:00 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiac Failure	
Arteriosclerotic Cardio-Vascular disease.	

Other significant conditions contributing to death but not related to principal cause given above

Was an operation performed? No Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19 .....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Nikos D. Polk M. D.

(Address) 7200 Fallon Ave

668777

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

Registered No. 668777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1715 ENSOR STREET
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yr. 1 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 ENSOR ST (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ETHEL LYNN HOWARD

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24, 1865

8. AGE: Years	Months	Days	If less than one day
82 83	11	27	hr. min.

9. Birthplace LEEDS, NEW YORK (Town, county, and state)
10. Usual Occupation WEAVER
11. Industry or business

FATHER
12. Name HYLAND W. HOWARD
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name CATHERINE HOLLANDBECK
15. Birthplace UNKNOWN

16 (a) Informant ESTHER BROWN TAYLOR
(b) Address 1715 ENSOR STREET

17 (a) CREMATION (Burial, cremation, or removal) (b) Date thereof Nov. 23-1948 (month) (day) (year)
(c) Cemetery or crematory
Location Loudon Park Cemetery

18 (a) Funeral director Joseph FARACE Inc.
(b) Address 2013 GREEN MOUNT AVE.

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1948, at 4 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May. 10, 1948, to Nov. 24 1948. and that I last saw her alive on Nov. 24 1948.

Immediate cause of death: Chronic Myocarditis — Duration: 4 months

Due to ✓

Due to ✓

Other Conditions None.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓ (City or town) ✓ (County) ✓ (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury ✓

23. Signature Francis X. Ogden M. D.
Address 2701 N. Calvert St Date signed Nov. 24 48

VS 150

X

G68778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 948

G68778

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 S. Chester St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(b) Street No. 322 S. Chester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Gajdzicki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Josefa

6 (c) If (a) give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65				

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Carroll Gajdzicki
13. Birthplace Poland

MOTHER
14. Maiden Name Prenta
15. Birthplace Poland

16 (a) Informant Jozefa Gajdzicki
(b) Address 322 S. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 (a) NOV 22 1948 (Local registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 20 1948, at 4 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26/48 to 11/8 1948 and that I last saw h[illegible] alive on 11/8 1948.

Immediate cause of death
Coronary occlusion — Duration: years

Due to arterio-sclerosis with hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sigmund R. Nowak M.D.
Address 408 S. Patt. Pl. Ave Date signed 11/22/48 M. D.

VS 150

8779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G68779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 546-St. Mary's Aff.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 546-St. Mary's Aff. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Lee Perry

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F. 5. Color or race Col. 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?-?-1926

8. AGE: Years 22 Months Days If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER 12. Name Charles Perry
13. Birthplace Ga. ?

MOTHER 14. Maiden Name Lelia ?
15. Birthplace S.C.

16 (a) Informant Lelia Perry
(b) Address 546-St. Mary's Aff.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location W. Fulstead

18 (a) Funeral director E. Reed & Sons
(b) Address 916 Penna Ave

19 (a) NOV 22 1948 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19- 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/16 1948 to 11-19 1948 and that I last saw h alive on 11/17 1948.

Immediate cause of death Pulmonary TBC — Duration 1 year

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Calvin B. LeCompte M.D.
Address 1113 H Cathedral Date signed 11/20/48

VS 193

668780 2 of 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1212

Registered No. 668780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1412 E Biddle St
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 E. Biddle St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Shelton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Howard

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 7-18-04

8. AGE: Years	Months	Days	If less than one day
44	4	1	hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Buttler
13. Birthplace S. C.

MOTHER
14. Maiden Name Katie Dean
15. Birthplace S. C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Wm J Jackson
(b) Address 9 Mrs Lenora Ave Huntington Williamsport, Md

19 (a) NOV 22 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 1948, at 320 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 1948 to 11-19 1948, and that I last saw her alive on 11-19 1948

Immediate cause of death Uremia — Duration

Due to Chronic glomerulonephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Small granular kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? - (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? - While at work?
(Specify type of place)
(e) Means of injury -

23. Signature Irwin Collins Harvey M. D.
Address Johns Hopkins Hospital Date signed 11-19-48

VS 150

G68781 4

ES-126719

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

8 3a

Registered No. G68781

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Ellison

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Sep.

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1890

8. AGE: Years	Months	Days	If less than one day
68 58			hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (b) Date thereof 11/23/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Wm A Jackson
(b) Address 844 Penna ave

19 NOV 22 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20 1948 at 2:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1948 to 11-20 1948, and that I last saw her alive on 11-20 1948.

Immediate cause of death Bronchopneumonia, bilat.
Due to recent cerebral accident
Due to arteriosclerosis & hemiplegia, rt.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Vickers J. M. D.
Address Balto City Hosp. Date signed 21 Nov 48.

VS 150

668782

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668782 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 657 Sterling St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 657 Sterling St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer Doctrins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alice Doctrins

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 18-1894

8. AGE: Years 54 | Months 57 | Days 4 | If less than one day: hr. min.

9. Birthplace Club Hill Balto. Co. Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Doctrins
13. Birthplace Eastern Shore Md

MOTHER
14. Maiden Name Hanna Barnes
15. Birthplace Hartford Co. Md

16 (a) Informant Alice Doctrins
(b) Address 657 Sterling St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22-48 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvery Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley ave

19 (a) Date received NOV 22 1948 (b) Registrar Huntington Hillsboro, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18-48 2:30 P. M. at

21. I certify that deceased died on the date above stated; that I attended deceased from 10-20-48 to 11-18-48.
and that I last saw him alive on 11-18-48.

Immediate cause of death: Bronchial Pneumonia — Duration: 4 wks
Due to: Secondary Anemia
Due to: Stroke — 8 wks.
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. R. Baker M. D.
Address 1603 N. Caroline Date signed 11-20-48

VS 150

G68783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G68783 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14 N. Montford Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 N. Montford Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME KONSTANTY NASURO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Stanislawa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) December 24, 1873

8. AGE: Years	Months	Days	If less than one day
74	10	25	hr. min.

9. Birthplace Wilno, Poland
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Retired

FATHER
12. Name Mikolaj Nasuro
13. Birthplace Wilno, Poland

MOTHER
14. Maiden Name Petronella Byslak
15. Birthplace Poland

16 (a) Informant Mr. Matthew Nasuro
(b) Address 14 N. Montford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 (a) Date received by registrar NOV 22 1948 (b) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1948 at 5 45 M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 18 1948 to Nov 19 1948, and that I last saw him alive on Nov 18 1948

Immediate cause of death	Duration
Senile Cardiac	
Due to Insufficiency	2 Hrs
Due to	
Other Conditions Bronchopneumonia	2 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roscoe G. Kincaid M. D.
Address 1438 Maryland Ave Date signed 11-20-48

95c

G68784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G68784 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 Monroe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** William Jones.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married.

6 (b) Name of husband or wife: Maggie Jones. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 10, 1885.

8. AGE: Years: 63 | Months: 8 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Calvert County, Md. (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER 12. Name: George Jones.
13. Birthplace: Calvert Co., Md.

MOTHER 14. Maiden Name: Priscilla Moore.
15. Birthplace: Calvert Co., Md.

16 (a) Informant: Mrs. Maggie Jones,
(b) Address: 616 Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23 1948 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location:

18 (a) Funeral director: Mrs Katie R. Williams
(b) Address: 322 N. Schroeder St.

NOV 22 1948 (Date received by Registrar) (b) Registrar: Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOV. 20 1948 at 5C. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1948 to NOV. 20 1948. and that I last saw h[illegible] alive on NOV. 20 1948

Immediate cause of death: Congestive Heart Failure

Due to: [illegible]

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: Eight

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature

Address Date signed 11-20-48

VS 150

G68785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68785

8:2a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2435 Foster Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2435 Foster Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET C. McCORD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George W. McCord
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9/2/1887

8. AGE: Years	Months	Days	If less than one day
61	2	18	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Home

FATHER
12. Name Frederick Kegel
13. Birthplace Maryland

MOTHER
14. Maiden Name Barbara ?
15. Birthplace Maryland

16 (a) Informant Ida Albert
(b) Address 2435 Foster Ave. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 (month) 23 (day) 48 (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave. Balto.

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto. 31, Md.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

NOV 22 1948

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 20 1948, at 9:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 48 to Nov. 20 19 48 and that I last saw her alive on Nov. 20 19 48.

Immediate cause of death	Duration
Cerebral Apoplexy	
Due to Arterio- sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eileen Zeller, M. D.
Address 2739 Eastern Ave. Date signed 11/22/48 M. D.

X

668786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. 668786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balls-Layson-Fayette
(c) Hospital or institution: Bon Secours 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 ds
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6119 Pimlico Rd (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Casimer Witkowski (CASIMIR FELIX WITKOWSKI)

MEDICAL CERTIFICATION

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Caroline V. Witkowski
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Nov 21 1883

8. AGE: Years 64 | Months 11 | Days 30 | If less than one day: hr. min.

9. Birthplace Poland (Town, county and state)

10. Usual Occupation Pres. of Business
11. Industry or business Training Institute

FATHER
12. Name Thos. Witkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Cecilia T. ?—
15. Birthplace Poland

16 (a) Informant Mrs Caroline V. Witkowski
(b) Address 6119 Pimlico Rd (wife)

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Nov 26 '48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore.

18 (a) Funeral director Stewart Mortuary
(b) Address 128 W Lanvale St

NOV 22 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

20. DATE OF DEATH Nov. 20 1948, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/6 1948 to 11/20 1948, and that I last saw him alive on 11/19 1948

Immediate cause of death	Duration
Respiratory Failure	
Due to Cong. Heart disease	
Due to Rheumatic heart disease	
Other Conditions arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify two of these)
(e) Means of injury

23. Signature D Schuhler
Address Bon Secours Hosp Date signed 11/20/48 M. D.

VS 150

#24 4W SC-48-12862 ✓ G68787

G68787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 2 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 MO.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 Talbot Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Edward Burke

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NO

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: CHILD

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-20-48

8. AGE: Years | Months: 5 | Days | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business

FATHER 12. Name William Burke
13. Birthplace Md

MOTHER 14. Maiden Name Norma Walsh
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-23-48 (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location WOODLAWN MD.

18 (a) Funeral director JOHN T. STANSBURY
(b) Address 2200 ERMONDSON AVE.

19 (a) (Date received by registrar) (b) Registrar

NOV 22 1948
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20-1948, at 6:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11-17-1948 to 11-20-1948, and that I last saw him alive on 11-20-1948.

Immediate cause of death: intra-cranial hemorrhage
Due to: aneurysm
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John J. Ryan M.D.
Address Johns Hopkins Hosp. Date signed 11/22/48

668788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

668788 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Genl DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town English Consul
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2736 Alderwood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amos R. Heller

3 (b) If veteran, name war: World No. 1

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Henrietta Heller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1878

8. AGE: Years 69 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation Inspector

11. Industry or business Highway Dept. Balto. City

FATHER
12. Name Cyrus Heller
13. Birthplace W. Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant: Mrs. Henrietta Heller
(b) Address 2736 Alderwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 22 1948 (b) Registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1948, at 11:45 P.M.

21. I certify that I took charge of the remains described above, held an Org Ed Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? Work at (Yes or No)
(d) Means of injury

23. Signature William J Helfrich M.D.
Medical Examiner.
Date signed 11/20/48

S 151

G68789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68789 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3806 Bonner Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3806 Bonner Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DELIA M. FUHRMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife George A. Fuhrman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1858

8. AGE: Years	Months	Days	If less than one day
90	0	20 21	hr. min.

9. Birthplace Westminster, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Josiah Babylon
13. Birthplace Md.

MOTHER
14. Maiden Name Lydia Haefley
15. Birthplace Md.

16 (a) Informant Miss Grace P. Fuhrman
(b) Address 3806 Bonner Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Krieder's Cem.
Location Westminster, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 22 1948 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1948 at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] to [illegible] and that I last saw h[illegible] alive on [illegible]

Immediate cause of death	Duration
[illegible]	[illegible]
Due to [illegible]	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed

VS 150

668790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 668790 Registered No. 1562

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3231 Normount Ave.
(c) Hospital or institution: No
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3231 Normount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN MILLER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-03-9957

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Hedwig F. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1903

8. AGE: Years	Months	Days	If less than one day
45	6	29	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business Miller Bros.

FATHER
12. Name Ferdinand Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Fredersdorff
15. Birthplace Germany

16 (a) Informant Mrs. Hedwig F. Miller
(b) Address 3231 Normount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 11/22/48 (b) [illegible] for Williams M.D. Registrar
Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1948 at 4:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from [illegible] 1948, to Nov 20 1948, and that I last saw h[illegible] alive on Nov 19 1948.

Immediate cause of death	Duration
[illegible]	about 3 yrs.
Due to	
Due to [illegible]	for [illegible] about 1 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed

VS 150

Cert. 668791

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 164c

668791 ✓ 668791
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 5611 Pimlico Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: JANE CHARLOTTE CULVER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Samuel H. Culver

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1909

8. AGE: Years 39 | Months 9 | Days 23 | If less than one day: hr. min

9. Birthplace Hagerstown, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Sterling K. Collier
13. Birthplace Petersburg, Va.

MOTHER
14. Maiden Name Lula May Fisher
15. Birthplace Piedmont, W. Va.

16 (a) Informant Dr. Samuel H. Culver
(b) Address 5611 Pimlico Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month, day, year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 22 1948 (Date rec'd by registrar) (b) Huntington Holloway M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20/48 19 at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide X, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gun Shot Wound, .38 Revolver
Right Temple

Due to

Other Conditions Marked Mental Depression
(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/20/48 at 4:55 P.M.
(b) Where did injury occur 5611 Pimlico Road
(c) Did injury occur at home, on farm, industrial place, in public place) Home (Specify)
(d) Means of injury Self Inflicted

23. Signature John L. D'Arcy M.D.
Medical Examiner.
Date signed 11/21/48

VS 151

668792

377508

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668792 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town LAWRENCE, (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 LAWRENCE, AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Celeste Thomas (Celesta)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col.	married

6 (b) Name of husband or wife Samuel Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-3-97

8. AGE: Years	Months	Days	If less than one day: hr.	min.
50	11	17		

9. Birthplace Ga. (Town, county, and State)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name Ernest Tabront
13. Birthplace N. C.

MOTHER
14. Maiden Name Lillie Armstrong
15. Birthplace Ga.

16 (a) Informant: records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Greenville
Location Hampstead Long Island N.Y.

18 (a) Funeral director Wm. S. Nelson
(b) Address 1303 Eastman Ave

19 NOV 22 1948 (Date rec'd by Registrar) (b) Huntington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. - 20 - 48. at 1 90 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-7- 1948 to 11-20- 1948 and that I last saw her alive on 11-20- 1948.

Immediate cause of death	Duration
CARCINOMATOSIS	9 mos
Due to CARCINOMA BLADDER INFILTRATING	9 mos
Due to	
Other Conditions Hydronephrosis	

(Include pregnancy within 3 months of death)

Date of operation APRI 1948
Major findings of operation: CARCINOMA BLADDER
of autopsy GENERALIZED Metastases

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Rivas Hauson, M.D.
Address Johns Hopkins Hosp. Date signed 11-21-48 (M.D.)

VS 153

G68793 PAIKOWSKY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G68793 Registered No.

1. PLACE OF DEATH: Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4004 Maine Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Abraham Paikowsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color of race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Paikowsky
13. Birthplace Russia

MOTHER
14. Maiden Name Jennie Williams
15. Birthplace Russia

15 (a) Informant Dr Hyman L Paikowsky
(b) Address 7 Wilson Park WaterVille Maine

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Portland Maine
Location Maine

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21-1948 at 11 P M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11-8-1948 to 11-21-1948, and that I last saw him alive on 11-21-1948.

Immediate cause of death Acute myocardial infarction — Duration

Due to Arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address Sinai Hosp. Date signed 11-21-48 M. D.

VS 150

68794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 68794

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 924 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME GILBERT ROSEVELT BROOKS

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Helen
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
41			..... hr. ..... min.

9. Birthplace Brokenberg, Virginia
(Town, county, and state)
10. Usual Occupation maintenance man
11. Industry or business Rheem Manufacturing Co.

FATHER
12. Name Ozie Brooks
13. Birthplace Brokenberg, Va.

MOTHER
14. Maiden Name Daisey Hairfield
15. Birthplace Brokenberg, Va.

16 (c) Informant Venton Hairfild
(b) Address 1515 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-48 (month) (day) (year)
(c) Cemetery or crematory Family Cemetery
Location Brokenberg, Va.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Hgts. Ave.

NOV 22 1948 (b) Huntington Williamsport, Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22, 1948, at 9.45a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary arteriosclerosis.

Due to.....

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?
(d) Means of injury.....

23. Signature Jorge E. Merrill M.D.
Medical Examiner.
Date signed November 22, 1948

VS 151

G68795

JL - 65255

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G68795
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
12
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No home Address
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Fainter (Francis F.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Ada
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, ?18?

8. AGE: Years	Months	Days	If less than one day
77 ?	9	27	hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Fainter
13. Birthplace Va.

MOTHER
14. Maiden Name Bridget
15. Birthplace Ireland

16 (a) Informant B. C. H. Records.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Washington, D. C.

18 (a) Funeral director Stephen J. Flemming
(b) Address 1426 Light St. Balto 30

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1948, at AM 7.52 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15, 1941 to Nov. 21 1948. and that I last saw him alive on Nov. 21 1948.

Immediate cause of death: Postmortem myocardial infarction — Duration 2 hrs

Due to: Arteriosclerotic Heart Disease.

Due to:

Other Conditions: Nephrosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Anatomic

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Hurley M. D.
Address Balt City Hosp Date signed Nov 22

VS 150

921

68796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 68796

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution:
ST. JOSEPH'S HOSP.

(d) Length of stay in hospital or inst. (~~yrs., mos.~~ or days) 45
(e) Length of stay in Baltimore (yrs., ~~mos. or days~~) 63

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 925 S. LINWOOD AVE. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. MINNIE WILHELMINA HANES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WID.

6 (b) Name of husband or wife Philip Hanes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 1, 1885

8. AGE: Years	Months	Days	If less than one day
63 63	10	18	hr. min.

9. Birthplace BALTO. MD. (Town, county, and state)
10. Usual Occupation HWFE.
11. Industry or business

FATHER
12. Name Henry Schoenfelder
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Pena
15. Birthplace Baltimore Md.

16 (a) Informant PATIENT
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23/48 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cemetery
Location O'Donnell St.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) NOV 22 1948 (b) Thurlington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1948 at 9 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1948 to 11-19 1948 and that I last saw her alive on 11-19 1948

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	3 DAYS
Due to HEPATO-RENAL SYNDROME	3 WKS.
Due to CARCINOMA OF LIVER	
Other Conditions CHOLECYSTITIS with STONES. PULMONARY INFARCTION (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: CANCER OF LIVER

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Joseph Krejci M. D.
Address 1400 N. Caroline St. Date signed 11-20-48

VS 150

G68797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No. G68797

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 Exton st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steve Formica

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-03-0567

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	

6 (b) Name of husband or wife: Janet Formica
6 (c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr): 11-26-94

8. AGE: Years	Months	Days	If less than one day
53	11	23	hr. min.

9. Birthplace: Italy (Town, county, and state)
10. Usual Occupation: Carpenter
11. Industry or business

FATHER
12. Name: ?
13. Birthplace: Italy

MOTHER
14. Maiden Name: ?
15. Birthplace: Italy

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22. 1948 (month) (day) (year)
(c) Cemetery or crematory Mem. Cathedral
Location Frederick Rd
Funeral director Wendell J. Keppel
(b) Address 315 S. Broadway
19 (a) NOV 22 1948 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948 at 9.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13 1948, to 11-19 1948, and that I last saw h[illegible] alive on 11-19 1948.

Immediate cause of death	Duration
Tuberculous Meningitis	2 wks
Due to Miliary Tuberculosis	2 wks
Due to Pulmonary Tuberculosis	10 mo
Other Conditions Tuberculous otitis, prostatitis, peritonitis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Tuberculosis Miliary

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard S Ross M.D.
Address 601 N. Broadway Date signed Nov 22 1948
Johns Hopkins Hosp.

VS 150

G68798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G68798

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — D.O.A.
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(c) City or town Baltimore Co. (If outside city or town limits, write RURAL and give county)
(d) Street No. 3657 Old York Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Granville Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife LAURETTE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV 14 1884

8. AGE: Years	Months	Days	If less than one day
64	0	8	hr. min.

9. Birthplace CANADA (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace CANADA.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace CANADA

16 (a) Informant ROBERT NELSON
(b) Address 3657 OLD YORK RD.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)
(c) Cemetery or crematory AMELIA COURT HOUSE
Location AMELIA Co. VIRGINIA

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St. Paul St.

NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22 1948 at 12 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Smith M.D. Medical Examiner.
Date signed 11/22/48

VS 151

68799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

Registered No. 68799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3102 Chesterfield Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3102 Chesterfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE E. HILDEBRAND

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Jacob B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 16, 1850

8. AGE: Years	Months	Days	If less than one day
98	10	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James H. Whiteley
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Julia Shipley
15 Birthplace Baltimore, Md.

16 (a) Informant George W. Pitt Sr.
(b) Address 3102 Chesterfield Ave.

17 (a) Burial (b) Date thereof 11/23/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 NOV 23 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1948 19 , at 10:20 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1948 to Nov 20 1948, and that I last saw her alive on Nov 20 1948.

Immediate cause of death Coronary occlusion — Duration

Due to Arteriosclerosis

Due to Chronic myocarditis

Other Conditions Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, industrial place)
(e) Means of injury

23. Signature Charles A. Anderson M. D.
Address 3001 Hillsmere Drive Date signed Nov 22-48

G68800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51R

G68800 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 Woodbrook Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3502 Woodbrook Ave (If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Markowitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1878

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town or county and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Israel
13. Birthplace Russia

MOTHER 14. Maiden Name Arena
15. Birthplace Russia

16 (a) Informant Family Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Druidsar Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2126 Eutaw Place

19 (a) NOV 23 1948 (Date rec'd by registrar) (b) Interment for Williams Mt

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21- 1948 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1935 to Nov 11 1948 and that I last saw him alive on 11-21 1948

Immediate cause of death
(a) Acute coronary Thrombosis — Duration 1 day
Due to (b) Arteriosclerosis — Duration 20 yrs
Due to (c)
Other Conditions — Duration 6 mos
Ca prostate (including pregnancy within 3 months of death)
Date of operation Sept 10, 1948
Major findings of operation: Ca of prostate
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph B Gross M. D.
Address 2426 Eutaw Place Date signed 22 Nov 48

VS 150

G8801 BC-48-2275 ✓ G8801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

Registered No. G68801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 949 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DIANA LYNN SLOAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1948

8. AGE: Years	Months	Days	If less than one day
	1	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clyde J. Sloan
13. Birthplace Va.

MOTHER
14. Maiden Name Angelina Herd
15. Birthplace 949 W. Lombard

16 (a) Informant Mr. Clyde A. Sloan
(b) Address 949 W. Lombard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmonson & Longwood

18 (a) Funeral director John J. Cowan
(b) Address 901-03 Hollins

19 Nov 22 1948 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1948, at 6:45PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Malnutrition

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Since birth ? at M.
(b) Where did injury occur? 949 W. Lombard St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Negligence

23. Signature [signature] M.D. Medical Examiner

Date signed 11/22/48

68802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68802

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3112 Leeds St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Leeds St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Genevieve L. Fuller

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16th 1854

8. AGE: Years	Months	Days	If less than one day: hr.	min.
94	1	6		

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at Home

FATHER
12. Name John Meisel
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore Md.

16 (a) Informant Mr Thomas J. Fuller
(b) Address 3112 Leeds St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Cowen & Son
(b) Address 901-03 Hollins St.

NOV 23 1948 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22nd 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1947 to 11/22 1948, and that I last saw her alive on Dec 11 1947

Immediate cause of death: Arteriosclerosis Cerebral thrombosis and softening of brain — Duration: 1 yr.

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(d) Means of injury

23. Signature John P. Uelsk, Jr. M.D.
Address 122 E Wash Blvd Date signed 11/24/48

VS 150

688803 CERTIFICATE CORRECTED 2-9-49. ✓ 688803

BALTIMORE CITY HEALTH DEPARTMENT

B.C. 48-28945

CERTIFICATE OF DEATH

6512 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? If yes, name country

3 (a) FULL NAME Carol Lee Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3-28-1948

8. AGE: Years | Months 9 | Days 23 | If less than one day hr min.

9. Birthplace Md. (Town, county and State)

10. Usual Occupation unemployed

11. Industry or business

FATHER 12. Name David Taylor
13. Birthplace Va.

MOTHER 14. Maiden Name Isabelle Gray
15. Birthplace Va.

16 (a) Informant David Taylor
(b) Address 1416 - Druid Hill St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Hallstead
(b) Address 918 - Druid Hill Ave.

19 (a) NOV 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 19 48 at 3.30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 3-15 1948 to 3-30 1948 and that I last saw her alive on Nov. 19 1948

Immediate cause of death Pulmonary Edema and Congestion — Duration 2 days

Due to Acute Bronchopneumonia

Due to

Other Conditions Hemorrhagic Nephritis and Endocarditis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature St. Elmo Brady, Jr. M. D.
Address Provident Hosp. Date signed 11-22-48

VS 159

107

G68804

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 82a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 da.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 W. West St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Ella Amelia Gottlieb (Gottlieb)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEM	WHITE	MARRIED

6 (b) Name of husband or wife: LEWIS GOTTLEIB
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 21 1879

8. AGE: Years	Months	Days	If less than one day
69	3	1	hr. min.

9. Birthplace: BALTIMORE MD (Town, county, and state)
10. Usual Occupation: HOUSE WIFE
11. Industry or business

FATHER
12. Name: JULIUS KIRCHNER
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: ANN A BROWN
15. Birthplace: GERMANY

16 (a) Informant: ELLA A GOTTLEIB
(b) Address: 720 W WEST ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV-26-48 (month) (day) (year)
(c) Cemetery or crematory: GLEN HAVEN CEM
Location: GLEN BURNIE MD

18 (a) Funeral director: Bernard E Hurle
(b) Address: 121 E West St

19 (a) NOV 28 1948 (Date) (b) by (Registrar) Registrar Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22 1948, at 6:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Oct. 1948, to 22 Nov. 1948, and that I last saw her alive on 22 Nov. 1948.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 hrs.
Due to Hypertension	6 mo?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature John Robert Shell M.D.
Address Mercy Hospital Date signed 22 Nov. 1948

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68805

161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Lake Shore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Pasadena P. O. (If rural give location)
(e) Citizen of foreign country? Md. (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Holmes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1948

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hugh Keiran Holmes
13. Birthplace

MOTHER
14. Maiden Name Margaret Ann Riplinger
15. Birthplace North Vernon, Ind.

16 (a) Informant Mr. Hugh Holmes
(b) Address Lake Shore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral.
Location

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount & 20th

19 (a) Nov 23 1948 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948 at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/17 1948 to 11/22 1948 and that I last saw him alive on 11/22 1948

Immediate cause of death	Duration
Respiratory Obstruction	5 days
Due to Atelectasis, left	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature James L. Hoodle, M.D.
Address St. Joseph's Date signed 11-22-48

VS 150

68806

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 121a

Registered No. 68806

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 Glyndon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
2 Street No. 1309 Glyndon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE M. CAVEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	212-09-8289

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 23, 1879

8. AGE: Years	Months	Days	If less than one day
69	9	28	hr. min.

9. Birthplace Frederick, Maryland (Town, county, and state)
10. Usual Occupation Operator, retired
11. Industry or business

FATHER
12. Name Arnold P. King
13. Birthplace Md

MOTHER
14. Maiden Name Julia (Unknown)
15. Birthplace Md

16 (a) Informant John A. Cavey
(b) Address 1309 Glyndon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 NOV 23 1948 (Date rec'd by registrar) (b) Interator Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1948 19 at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 19 46 to Nov. 21 19 48. and that I last saw her alive on Nov 21 19 48.

Immediate cause of death Hypertensive Cardiov Vasculer - Renal Disease — Duration 3 years
Due to Arteriosclerosis
Due to
Other Conditions Chronic Nephritis — 10 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature John P. Ulrich, Jr
Address 1227 Wash Blv'd Date signed 11/22/48 M D

VS 150

55807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 168807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3201 Presbury St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Presbury St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cameron Fitzhugh Bayrle

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~or wife~~ William C. Bayrle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1892

8. AGE: Years	Months	Days	If less than one day
56	9	16	hr. min.

9. Birthplace Culpepper, Va.
(Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business

FATHER
12. Name William DeHart Fitzhugh
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth Grayson
15. Birthplace Culpepper, Va.

16 (a) Informant William C. Bayrle
(b) Address 3201 Presbury St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-1948 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) NOV 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 8.00

20. DATE OF DEATH November 21, 1948 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16 1944 to 11/21 1948.
and that I last saw her alive on 11/20 1948.

Immediate cause of death Coronary occlusion — Duration 3 days.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Reiter M.D.
Address 34 of Windsor Ave. Date signed 11/22/48

VS 150

68808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68808

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 N. Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRED MILTON TRESCHLER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife Rose Treschler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1893.

8. AGE: Years	Months	Days	If less than one day
55	1	12	hr. min.

9. Birthplace Switzerland.
(Town, county, and state)
10. Usual Occupation Automobile Salesman.
11. Industry or business

FATHER
12. Name ? Treschler.
13. Birthplace Switzerland.

MOTHER
14. Maiden Name Marie Wasser,
15. Birthplace Switzlerland.

16 (a) Informant Mrs. Rose Treschler,
(b) Address 2215 N. Pulaski St.

17 (a) Cremation (b) Date thereof 11/23/48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Balto. Md.

18 (a) Funeral director Harold Lansinger Sons
(b) Address 1902 Eutaw Place.

19 NOV 23 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21st. 1948, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 19-7 to Nov 21 19-8 and that I last saw h-- alive on Nov 18 1948.

Immediate cause of death	about	Duration
Cardio occlusion		1 hr.
Due to Cardiovascular disease		avaat 1 year
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Stuart M. D.
Address 2220 Garrison Blvd. Date signed NOV 24

VS 150

Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23 are especially important. Physicians: please write the causes of death clearly and legibly. Funeral director: please see that all items are complete before the ceremony supplied.

68809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. 68809

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Foot of Anne St.
(c) Hospital or institution:

17

(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 542 Oxford Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: WILLIAM L BURTON

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	married

6 (b) Name of husband or wife: Estella Burton
6 (c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace: Crisfield, Md.
(Town, county, and state)

10. Usual Occupation: Porter
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Estella Burton
(b) Address: 542 Oxford Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary Cem.
Location: Brooklyn, Md.

18 (a) Funeral director: Elroy O. Wilson
(b) Address: 1000 Brantly Avenue

19 (a) NOV 23 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22, 1948 at 6.45 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Drowning

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 2/3
(a) Date of injury: Found: 11-22-48 at 6.45 a. M.
(b) Where did injury occur? Found Foot of Anne St.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? ?
(d) Means of injury: Found Drowned

23. Signature: Earl L. Royer M.D.
Medical Examiner.
Date signed: November 2, 1948

VS 181

68810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 68810

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2249 N. Pine St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2249 N. Pine St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME George Washington Gibbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Mary Gibbs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1903

8. AGE: Years	Months	Days	If less than one day
45	5	23	hr. min.

9. Birthplace Woodhaven N. C.

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name James Gibbs

13. Birthplace Jamaica W. Indies

MOTHER

14. Maiden Name Irene ?

15. Birthplace N. C.

16 (a) Informant Mary Gibbs

(b) Address 2249 N. Pine St.

17 (a) Burial (b) Date thereof Nov. 22, 1948

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) NOV 22 1948 (b) Huntington Williams, M.D.

(Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1948 at 10:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12/48 to 11/20 1948.

and that I last saw him alive on 11/19 1948.

Immediate cause of death Intermediate Heart Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration ?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Wm Garner

Address 213 Gough St Date signed 11/22/48

Garner X

VS 150

68811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 68811

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5414 Dennmore Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5414 Dennmore Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Rev. James W. Boston.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Bessie Boston.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 22, 1888.

8. AGE: Years: 60 | Months: 9 8 | Days: 25 | If less than one day: hr. min.

9. Birthplace: West River, Md.. (Town, county, and state)

10. Usual Occupation: minister

11. Industry or business

FATHER — 12. Name: Richard R. Boston.

13. Birthplace: Md..

MOTHER — 14. Maiden Name: Rebecca Johnson.

15. Birthplace: Md.

16 (a) Informant: Bessie Boston.

(b) Address: 5414 Dennmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24, 1948 (month) (day) (year)

(c) Cemetery or crematory: Mt. Auburn

Location

18 (a) Funeral director: Mrs Katie R Williams

(b) Address: 323 N. Schroeder St.

19 (a) NOV 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 1948. at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 1948. to 11-19 1948. and that I last saw h/z alive on 11-19 1948.

Immediate cause of death: Acute Coronary occlusion — Duration: —

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address 1349 Pennsa Ave Date signed 11/23/48 M. D.

VS 150

68812

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 166

Registered No. 68812

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 Salem St. (If rural give location) 2534
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALTON SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella Mae Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1910

8. AGE: Years 38 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Greenville, S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Smith
13. Birthplace Greenville, S.C.

MOTHER
14. Maiden Name Maggie
15. Birthplace Greenville, S.C.

16 (a) Informant: Ella Mae Smith
(b) Address 2534 Salem St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Nov. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Greenville S. C,
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Longwood St

19 (a) NOV 23 1948 (Date received by registrar) (b) Huntingtown Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1948 at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 20, '48 Approx. 7:15 P.M.
(b) Where did injury occur? 2448 Francis St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Emil Ross M.D. (Medical Examiner)
Date signed 11/22/48

VS 151

X

68813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. 68813

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Lombard Sts

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2422 Frances St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Elizabeth Too Good

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Widow

6 (b) Name of husband or wife John Toogood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 28, 1887

8. AGE: Years	Months	Days	If less than one day: hr.	min.
61	7	23		

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jacob ?

13. Birthplace A.A. Co. Md.

MOTHER 14. Maiden Name Frances

15. Birthplace Md.

16 (a) Informant Margaret Green

(b) Address 1422 N. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23 1948 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial

Location

18 (a) Funeral director Mrs Peter R. Williams

(b) Address 322 N. Schroeder St

19 (a) NOV 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20/48 19 . at 1.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 15 1948 to NOV 20 1948 and that I last saw her alive on NOV 20 1948

Immediate cause of death	Duration
Cardiac failure	
Due to hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/18/48

Major findings of operation: none obvious

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank E Bamberger M.D.

Address University Hosp Date signed 11/24/48

VS 150

68814

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12B

Registered No. 68814

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 W. Chase Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 W. Chase Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: HERBERT AQUILLA BRAXTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Roberta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 12, 1905

8. AGE: Years 43 | Months 4 | Days 8 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland.
(Town, county, and state)

10. Usual Occupation: Porter

11. Industry or business:

FATHER
12. Name: George Braxton
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Maude Hooker
15. Birthplace: Virginia

16 (a) Informant: Mrs. Maude Braxton
(b) Address: 523 N. Hoffman Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/1948 (month) (day) (year)
(c) Cemetery or crematory: St. Peters
Location: Baltimore, Maryland

18 (a) Funeral director: Mrs. George H. Holland
(b) Address: 1631 Druid Hill Ave.

19 (a) NOV 23 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

a/

20. DATE OF DEATH November 21, 1948 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1948 to Nov 21 1948.
and that I last saw him alive on Nov 20 1948

Immediate cause of death: Pulmonary Tuberculosis — Duration: History indefinite

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: R. Garland Ghrist M.D.
Address: 1534 Druid Hill Ave Date signed: Nov 22

VS 150

G68815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G68815
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM PHILLIP DANIELS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife Cornelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1870

8. AGE: Years	Months	Days	If less than one day
78	7	13	hr. min.

9. Birthplace Oxford, N.C.
(Town, county, and state)

10. Usual Occupation Moulder

11. Industry or business

FATHER
12. Name James Daniels
13. Birthplace Oxford, N.C.

MOTHER
14. Maiden Name Esther ?????
15. Birthplace North Carolina

16 (a) Informant Mrs. Minnie Smith
(b) Address 912 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 23 1948 (b) (Date rec'd by registrar) Huntington Williams, MD

MEDICAL CERTIFICATION

p/

20. DATE OF DEATH November 21, 1948 12:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 12 1948 to Nov 21, 1948 and that I last saw him alive on Nov 21 1948

Immediate cause of death: Cerebral Hemorrhage — Duration: 9 days

Due to hypertensive cardio-vascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Kemp Lyon M. D.
Address 803 [illegible] Date signed 11-22-48

VS 150

68816

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

68816
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2319 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 ?
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2319 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARTHA ROBINSON WHITE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1858

8. AGE: Years	Months	Days	If less than one day: hr.	min.
90	1	22		

9. Birthplace Warrenton, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Elzey Robinson
13. Birthplace Warrenton, Va.

MOTHER
14. Maiden Name Lucy Ball
15. Birthplace Warrenton, Va.

16 (a) Informant Mr. William H. White
(b) Address 2319 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 23 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION 8/

20. DATE OF DEATH November 22, 1948, at 5:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1, 1948, to Nov 22, 1948, and that I last saw her alive on Nov 20, 1948

Immediate cause of death: Arteriosclerosis — Duration
Due to: Senility
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature McDonald Bando M. D.
Address 2445 Druid Hill Ave Date signed 11-22-48

VS 193

68817 ✓ 68817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No.

LCH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN BAILEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 3/24/1882

8. AGE: Years	Months	Days	If less than one day
66	7	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Levin Bailey
13. Birthplace Maryland

MOTHER
14. Maiden Name Ann Pipkett
15. Birthplace Maryland

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Nov. 24, '48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Mohland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 23 1948 (Date received by registrar) Hunter for Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 19 48 at 6:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/ 19 48 to 11/20 19 48
and that I last saw h im alive on 11/20/ 19 48

Immediate cause of death
Fibro caseous tuberculosis of upper lobe

Due to

Due to

Other Conditions Hypertensive Heart Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Welch M.D.
Address Balto City Hosp Date signed 24 Nov 48

VS 150

G68818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

Registered No. G68818

Please write clearly and legibly. Use the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 Roslyn Ave.
(c) Hospital or institution:
none 15-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 Roslyn Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Walter A. Burall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 18, 1864

8. AGE: Years	Months	Days	If less than one day: hr.	min
84	2	3		

9. Birthplace New London, Frederick Co., Md. (Town, county, and state)
10. Usual Occupation Locomotive Engineer
11. Industry or business retired 18 yrs.

FATHER
12. Name Oliver Burall
13. Birthplace New Market, Fred. Co., Md.

MOTHER
14. Maiden Name Annie E. Gray
15. Birthplace New Market, Fred. Co., Md.

16 (a) Informant Miss Helen M. Burall
(b) Address 2215 Roslyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-48 (month) (day) (year)
(c) Cemetery ~~crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John L. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) NOV 23 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1948, at M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1948 to Nov 21 1948 and that I last saw ... alive on Nov 21 1948

Immediate cause of death: Renal Insuffi-ciency — Duration 2 wks

Due to Prostatism — 2+ yrs

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carroll Lockard, M.D.
Address 2925 N. Charles St. Date signed 22 Nov 48

VS 153

68819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. 68819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Street
(c) Hospital or institution: St. Joseph's Hospital. 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 5
City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1147 Gorsuch Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gordon Sutton Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/6/96

8. AGE: Years	Months	Days	If less than one day: hr.	min.
52	4	15		

9. Birthplace Kansas City, Kansas. (Town, county, and state)
10. Usual Occupation Foreman - N.B.C. Steamship
11. Industry or business Line.

FATHER
12. Name John Smith
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Davis
15. Birthplace Baltimore

16 (a) Informant Mrs. Carl Working
(b) Address 1147 Gorsuch Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

NOV 23 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1948, at 4:57 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/6/48 19... to 11/21/48 19...
and that I last saw him alive on 11/21/48 19...

Immediate cause of death	Duration
Cardiac respiratory failure	
Due to Pneumonia,	
Due to Post. P. Abdominal incisional reaction for Cancer of rectum.	

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 11/11/48
Major findings of operation: Cancer of rectum.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gerhart A. Rockey M.D.
Address St. Joseph's Hospital Date signed 11/21/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96

Registered No. G68830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3348 Hickory Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN E. HOOD

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-09-3784

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mabel F. Hood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1880

8. AGE: Years	Months	Days	If less than one day
68	7	7 6	hr. min.

9. Birthplace Baltimore County (Town, county, and state)
10. Usual Occupation Ret.
11. Industry or business Baltimore Transit Co.

FATHER
12. Name Holmes Thomas Hood
13. Birthplace Baltimore County

MOTHER
14. Maiden Name Hannah Catherine White
15. Birthplace Baltimore County

16 (a) Informant Mrs. Mabel F. Hood
(b) Address 3348 Hickory Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-48 (month) (day) (year)
(c) Cemetery or crematory St. Marys (Hampden)
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3611 Falls Rd. Baltimore Md.

19 (a) NOV 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21- 19 48 at 11 58 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18- 19 48 to 11-21 19 48 and that I last saw him alive on 11-21- 19 48.

Immediate cause of death Cardiac failure — **Duration**

Due to Rupt arteriosclerosis 4 days

Due to Gen arteriosclerosis

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 11-21

VS 150

68821

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. 668821

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 North Pulaski Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 North Pulaski Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FENA FISCHER

3 (b) If veteran, name war ********
3 (c) Social Security Account No. *********

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife BERHARDT-FISCHER
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr) Apr. 10-1863

8. AGE: Years	Months	Days	If less than one day
85	6 7	1 9	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife At
11. Industry or business Home

FATHER
12. Name ? Clemer-
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Miss Lena Fischer
(b) Address 2101 N. Pulaski Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 23 Nov. 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Maryland

18 (a) Funeral director F. B. NIPPERT & SON
(b) Address 13000 EUTAW PLACE 17

19 (a) NOV 22 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1948, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1948 to Nov 11 1948 and that I last saw h-R alive on Nov 11 1948.

Immediate cause of death	Duration
Coronary Sclerosis due to Arteriosclerosis and Senility	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury.

23. Signature Huntington Williams, M. D.
Address 1035 N. Eutaw St. Date signed

VS 150

Fill in all blanks. Print, write the causes of death clearly and legibly.

INSLEY ✓

68822 BALTIMORE CITY HEALTH DEPARTMENT 68822

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 WILLIAM ST.
(c) Hospital or institution:
24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 WILLIAM ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose E. Insley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | **5. Color or race** W | **6 (a) Single, married, widowed, or divorced** WIDOWED

6 (b) Name of husband or wife THOMAS H. INSLEY

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) JAN 17, 1888

8. AGE: Years 60 | Months 10 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name HENRY L. WICKLEIN
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace "

16 (a) Informant MR. JOSEPH A. DETTENTALER
(b) Address 3608 WHITE AVE

17 (a) BURIAL (Burial, cremation, or removal) **(b) Date thereof** 11/24/48 (month, day, year)
(c) Cemetery or crematory LORRAINE PARK
Location WOODLAWN, MD.

18 (a) Funeral director JOHN E. DENNY, INC.
(b) Address 715 LIGHT ST. -30

19 (a) NOV 23 1948 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Nov. 1948, at 3 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease.

Due to —

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammer, Jr. M.D.
Medical Examiner.
Date signed 21 Nov. 48

VS 151

92

668823

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

668823 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3312 Chestnut Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Pr Geo
(c) City or town Bowie
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helena Flaherty Chartero

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1866

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Pr. Geo Co Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name Charles Flaherty
13. Birthplace Germany

MOTHER
14. Maiden Name Teresa Born
15. Birthplace Germany

16 (a) Informant Helena A Charters
(b) Address Bowie Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 25 46 (month) (day) (year)
(c) Cemetery or crematory Ascension
Location Bowie Md

18 (a) Funeral director Morton Flaherty Sons
(b) Address Bowie Md

19 (a) NOV 22 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1946, at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1946 to Nov 22 1946 and that I last saw h[illegible] alive on Nov 22 1946

Immediate cause of death	Duration
(a) Heart failure	
Due to (b) Old [illegible]	
Due to (c) [illegible]	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 646 W 36 St Date signed 23 Nov 46

VS 150

G68824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68824

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 Woodington Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Woodington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA LEE WHEELER

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Marean N. Wheeler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 12, 1869

8. AGE: Years 79 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace Leesburg, Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles O'Conner
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Idelle Taylor
(b) Address 607 Woodington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory Trinity Chapel
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 23 1948 (Date rec'd by registrar) (b) Timothy Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1948 at 2:29p M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 29 1948 to Nov 20 1948 and that I last saw h[illegible] alive on Nov 19 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 days
Antecedent
Due to: General Arteriosclerosis
Due to: Arteriosclerosis
Other Conditions: Bronchial Pneumonia — 2 days
(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] (M.D.)
Address 1219 Eastern Ave. Date signed 11/22/48

VS 150

G68825

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 c

Registered No. G68825

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 Belle Grove Rd. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret McVey

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-20-3175

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Everett B. McVey
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) 10/30/1895

8. AGE: Years	Months	Days	If less than one day
53	0	22	hr. min.

9. Birthplace Wisconsin (Argyle) (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Cornelius Julius Donahue
13. Birthplace Stockton, Ill.

MOTHER
14. Maiden Name Margaret M. Myers
15. Birthplace Waterford, Ontario, Canada

16 (a) Informant Mr. Everett B. McVey
(b) Address 16 BelleGrove Rd., Catonsville

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory
Location Freeport, Ill.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 23 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22/1948, at 2:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1948, to 11/22 1948, and that I last saw her alive on 11/22 1948.

Immediate cause of death	Duration
Pulmonary congestion & edema	
Due to Rheumatic heart disease with aortic stenosis	yrs?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Rheumatic CVD with aortic stenosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert J. Kirchner M. D.
Address St. Agnes Hospital Date signed 11/22/48

VS 150

G68826 ✓ G68826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md. (b) County U. S. A.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 Victory Ave, 25 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Chauncey D. Christman
3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Veda M. Christman
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 10-18-1864

8. AGE: Years	Months	Days	If less than one day
84	1	4	hr. min.

9. Birthplace Lykers N. Y. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business —

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mrs. Milicent K. Christman
(b) Address 922 Victory Ave. Balto.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory
Location Cobleskill, N. Y.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) Nov 22 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22 1948, at 11:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1948 to 11-22 1948 and that I last saw him alive on 11-22 1948.

Immediate cause of death Intrahepatic thrombosis - portal vein — Duration 3-5 days
Due to
Due to
Other Conditions old myocardial infarct, pulmonary congestion (Include pregnancy within three months of death)
Date of operation None
Major findings of operation:
of autopsy: as given above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert J. Lerchen
Address St. Agnes Hospital Date signed 11/22/48 M. D.

VS 159

100 L.

G68827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G68827

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3024 Auchentoroly Terr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ANNIE KATHERINE BLANCK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1875

8. AGE: Years	Months	Days	If less than one day
73	1 2	18	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Oscar Blanck
13. Birthplace Germany

MOTHER
14. Maiden Name Mary A. Thies
15. Birthplace Germany

16 (a) Informant Mrs. Arthur H. Miller
(b) Address 3024 Auchentoroly Terr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11.24.48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address North & Pa. Aves., Balto.

19 (a) NOV 29 1948 (Date rec'd by registrar) (b) Huntington, Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948 at 1:00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 13 1948 to Nov 22 1948, and that I last saw h[illegible] alive on Nov 22 1948

Immediate cause of death Carcinomatosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2033 Eutaw Pl. Date signed 11-24-48

VS 150

668828

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

927

Registered No. 668828

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3918 Cloverhill Rd.
(c) Hospital or institution:

(d) Lengtl. of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3918 Cloverhill Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA MARGARET KIRBY

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Thomas Milton Kirby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1875

8. AGE: Years	Months	Days	If less than one day
73	1	10	hr min

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Meeth
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Schriver
15. Birthplace Germany

16 (a) Informant Mr. T. M. Kirby
(b) Address Briarstone Rd., Randallstown

17 (a) Burial (b) Date thereof 11/24/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Balto., Md.

19 (a) NOV 23 19[illegible] (b) [illegible]
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948, at 8:30a M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1948, to Nov. 22 1948, and that I last saw h[illegible] alive on Nov. 20 1948

Immediate cause of death Uraemia Fibrillation — Duration Months

Due to Arterio-Sclerotic heart disease — Duration years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 325 S. Paca St. Date signed 11/27/48
M D.

VS 150

G68829

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G68829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 Compton St.
(c) Hospital or institution:
24 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 Compton St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA WALTON

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Frank E. Walton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1890

8. AGE: Years 58 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Daniel Anderson
13. Birthplace Balto.

MOTHER 14. Maiden Name Annie McCurley
15. Birthplace Balto. Md.

16 (a) Informant Anna A. Somers
(b) Address 2212 Christian St. 23

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 25 1948 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A Co.

18 (a) Funeral director A. Howard Evans
(b) Address 1000 S. Charles St.

19 (a) NOV 23 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948 at 6 AM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes x, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Rogers M.D.
Medical Examiner
Date signed 11/23/48

VS 181

66880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

66880 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Burns

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	Colored	Common-Law

6 (b) Name of husband or wife Alice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-22-94

8. AGE: Years	Months	Days	If less than one day: hr.	min.
54	8	27		

9. Birthplace Texas (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name	Major Burns
FATHER 13. Birthplace	Texas
MOTHER 14. Maiden Name	Louise
MOTHER 15. Birthplace	Texas

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Joseph B. Loeb
(b) Address 1304 N. Central Ave.

19 NOV 23 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1948 at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1948 to 11/21 1948 and that I last saw him alive on 11/21 1948

Immediate cause of death	Respiratory failure	Duration
Due to	Esophagectomy	
Due to	Carcinoma of esophagus	
Other Conditions	[redacted]	

(Include pregnancy within three months of death)

Date of operation Nov. 20, 1948
Major findings of operation: Carcinoma of esophagus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A.M. P.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard T. Leffler Jr. M.D.
Address Johns Hopkins Hosp. Date signed 11/23/48

VS 150

G68831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G68831

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Ensor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES HOWARD SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-10-1894

8. AGE: Years	Months	Days	If less than one day
54 smt	5	12	hr. min

9. Birthplace Pennsylvania
10. Usual Occupation Laborer (Town, county, and state)
11. Industry or business

FATHER
12. Name ?
13. Birthplace Pa.

MOTHER
14. Maiden Name ?
15. Birthplace Pa.

16 (a) Informant Mary Thomas
(b) Address 1015 Ensor Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Joseph L. Locke
(b) Address 1320 N. Eutaw St.

19 (a) NOV 22 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948 at 6:50 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
~~Cystitis~~
congestive heart failure
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 11/23/48

VS 151

668832

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1210

Registered No. 668832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 N Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 N Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Hawkins Watts.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife William Watts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/17/1904

8. AGE: Years 44 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business Md Discount Co.

FATHER 12. Name David Hawkins
13. Birthplace Md

MOTHER 14. Maiden Name Frances Thomas
15. Birthplace Md

16 (a) Informant Lilly Taylor (S)
(b) Address 508 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaac L Brown & Son
(b) Address 108 W Montgomery St

19 (a) Nov 23 1948 Registered by Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20/48 19 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1948 to 11/20 1948.
and that I last saw her alive on 11/20 1948

Immediate cause of death Coronary Thrombosis

Due to Hypertension Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hans Trumbauer M D

Address 22 W Lee Date signed 11/22/48

668833 CURRY

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. 668833

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1138 Warner St
(c) Hospital or institution:
21-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1138 Warner St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Mamie Curry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	

6 (b) Name of husband or wife: Malachi Curry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19 1885

8. AGE: Years	Months	Days	If less than one day:
63	5	-	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jos Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Harris
15. Birthplace Md

16 (a) Informant Malachi Curry
(b) Address 1138 Warner St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/48 (month) (day) (year)
(c) Cemetery or crematory AC Md Mt Calvary Cem
Location Isaac L Bowman Son

18 (a) Funeral director Lodge Monty Murray St
(b) Address

19 (a) NOV 29 1948 (b) Permanent for Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1948, at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from NOVEM 10, 1948 Nov 19 1948. and that I last saw HER alive on Nov 18 1948.

Immediate cause of death: Respiratory failure — Duration

Due to arteriosclerotic Cardio vascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Sborofsky M.D. M. D.
Address 2010 Monroe St Date signed 11/22/48

VS 150

68834

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. 68834

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 N.Streeper Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 N.Streeper Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Kopper

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George B.Kopper
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): Dec. 7th., 1873

8. AGE: Years: 74 | Months: II | Days: I4 | If less than one day: ##### min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: William Herberich
13. Birthplace: Germany

MOTHER
14. Maiden Name: Magda len Schmitt
15 Birthplace: Germany

16 (a) Informant: Mrs. John B.Kopper-- Son
(b) Address: 2011 Sinclair La.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof II/24/48 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Road, Balto:Md.

18 (a) Funeral director: George J.Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) NOV 25 1948 (b) Registrar for Williams M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21- 1948, at 6P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12- 1946, to 11-21- 1948, and that I last saw her alive on 11-20-1948.

Immediate cause of death	Duration
Coronary Thrombosis	Days
Due to Arteriosel. C.V. disease	2 years
Due to Arteriosclerosis	
Other Conditions Diabetes mellitus	5 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benj. B. Morgan M.D.
Address 1418 N. Regester Ave Date signed 11-22-48 M. D.

V S 150

937

G68835

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68835 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway at Fairmont
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Cambridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 Gay Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Robert Pink

3 (b) If veteran, name war: No

3 (c) Social Security Account No. Not Known

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Margaretha Pink

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr) 4/15/75

8. AGE: Years 73 | Months 7 | Days 7 | If less than one day: hr. min.

9. Birthplace Brooklyn, N. Y.
(Town, county, and state)

10. Usual Occupation Business Man

11. Industry or business Wire Cloth Manufacture

FATHER
12. Name Robert Pink
13. Birthplace England

MOTHER
14. Maiden Name Marya Roberts
15. Birthplace England

16 (a) Informant Hospital Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/22/48 (month) (day) (year)
(c) Cemetery or crematory
Location Cambridge, Md.

18 (a) Funeral director Emmett L. Thomas
(b) Address Cambridge, Md.

19 (a) NOV 23 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23-48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13-48 19 , to Nov 23 19 48, and that I last saw him alive on Nov 23, 19 48.

Immediate cause of death: Cardiac failure
Due to: Bronchopneumonia
Due to: Ulceration Larynx

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None to date

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. W. Murphy
Address Church Home Date signed 11 22 48

VS 150

688.36

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

688.36
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or ~~INSTITUTION~~ St. Joseph's 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 N. Loudon Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mullin, James Cornelius

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 29, 1865

8. AGE: Years	Months	Days	If less than one day: hr.	min.
83	1	22		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John B. Mullin
13. Birthplace ~~Baltimore~~ Ireland

MOTHER
14. Maiden Name Mary E. McAuliffe
15. Birthplace Baltimore

16 (a) Informant Frank Mullin
(b) Address 513 N. Loudon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave. & Franklin St.

19 (a) NOV 23 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1948 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16, 1948 to Nov. 21, 1948 and that I last saw him alive on Nov. 21, 1948

Immediate cause of death	Duration
Hypostatic Pulmonary Congestion.	
Due to Hypertensive Retinio-	
Due to Sclerotic Heart Disease	

Other Conditions
Epistaxis
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Robert T. Everett M. D.
Address [illegible] Date signed 11/21/48

VS 150

57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 668837

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Hayden & Hilleland Sts

(c) Hospital or institution West Baltimore General Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1121 Calvert St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Einar Nees

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 501-01-8123

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Married

6 (b) Name of husband or wife Jessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2 1905

8. AGE: Years	Months	Days	If less than one day: hr.	min.
43	1	20		

9. Birthplace Oslo Norway (Town, county, and state)

10. Usual Occupation Chef

11. Industry or business

FATHER 12. Name Christian Nees

13. Birthplace Norway

MOTHER 14. Maiden Name Carolina Andersen

15. Birthplace Norway

16 (a) Informant Mrs Jessie Nees

(b) Address 1121 W Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Baltimore Md

18 (a) Funeral director Fulhorn & Lee

(b) Address 1217 W Fayette St

19 NOV 24 1948 (Date rec'd by Registrar) (b) Custis for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Nov 1948 at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Nov 1948 to 22 Nov 1948 and that I last saw him alive on 22 Nov 1948.

Immediate cause of death Bronchio-glioma Carcinoma

Due to Cause unknown.

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Confirmatory

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? None (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. P. Young M. D.

Address W. B. G. Hospital Date signed 22 Nov 48

VS 150

68838 ✓ 668838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 115 W. Barre Street
(c) Hospital or institution:
22
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 W. Barre Street (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Nunzio Prestianni

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Louise
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr) May 18, 1884

8. AGE: Years	Months	Days	If less than one day
64	6	5	..... hr. ..... min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Trackman
11. Industry or business B. & O. R. R. Co.

FATHER
12. Name Nunzio Prestianni
13. Birthplace Italy

MOTHER
14. Maiden Name Nunzia Russo
15. Birthplace Italy

16 (a) Informant Nancy Yannuzzi
(b) Address 4006 Century Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) NOV 24 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1948, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1948, to Nov 23 1948, and that I last saw h[illegible] alive on Nov 21 1948.

Immediate cause of death Coronary Thrombosis

Due to arter. Sclerosis.

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dan'l Drennen M.D.
Address [illegible] Lee Date signed 11/23/48

VS 153

X

G688.39

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G688.39

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-11-22 13
(e) Length of stay in Baltimore (yrs., mos., or days) 12yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th Street. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nina Fountain Nicholson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	widower

6 (b) Name of husband or wife Eugenia Payne Nicholson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June. 30 - 1866

8. AGE: Years 82 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Caroline Co, Md. (Town, county, and state)

10. Usual Occupation Insurance

11. Industry or business

FATHER
12. Name William G. Nicholson
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret E. Fountain
15. Birthplace Maryland

16 (a) Informant Laura E. Fischer - Night Sup.
(b) Address 700 West - 40th St -

17 Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director Pulhorn & Son
(b) Address 1217 Park Ave

19 (a) NOV 24 1948 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22. 1948. at 10 30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/30 1946. to 11/22 1948. and that I last saw h alive on 19

Immediate cause of death	Duration
Arteriosclerotic Heart Disease.	4 years
Due to Arteriosclerosis (Generalized)	10 years
Due to	
Other Conditions Chronic Bronchitis	30 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hergenroeder M. D.
Address 214 Medical Arts Bldg Date signed 11/23/48

VS 153

6688-0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC-48-25490 157 M

Registered No. 6688-0

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light Street

(c) Hospital or institution: South Baltimore General Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1301 Andre Street (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Baby Boy Reisinger.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11 20 48

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William E. Reisinger

13. Birthplace Md.

MOTHER 14. Maiden Name Florence Glenn

15. Birthplace Md.

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School NOV 23 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) NOV 24 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1948 at 8:42 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1948 to 11-21 1948 and that I last saw h alive on 19

Immediate cause of death: Atelectasis of the Newborn — Duration 1 day

Due to Congenital Atresia, Left Main Bronchus — Duration 1 day

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-20-48

Major findings of operation: Congenital atresia, Left Main Bronchus

of autopsy: Atelectasis, 5 lobes

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward A. Newell M. D.

Address 1213 Light Street Date signed 11-21-48

VS 150

68841

ES-98127

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46F

6688:1 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 Grindell Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Febee (FEBBER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ?

8. AGE: Years	Months	Days	If less than one day
80?			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 23 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 24 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14 1948, at 12:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1945 to 11-14 1948 and that I last saw him alive on 11-14 1948

Immediate cause of death	Duration
Carcinoma of liver Primary? Le Boudary	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. T. Wilson M. D.
Address BCH Date signed 11-22-48

VS 150

68842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 B

Registered No. 68842

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2827 Miles Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 Miles Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No)
If yes, name country

3 (a) FULL NAME John A. Snouffer.

3 (b) If veteran, name war ----------

3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	Widowed.

6 (b) Name of husband or wife Lillie M. Snouffer.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1886

8. AGE: Years	Months	Days	If less than one day
62	1		hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Iceman.
11. Industry or business

FATHER 12. Name Richard T. Snouffer.
13 Birthplace Md.

MOTHER 14. Maiden Name Carrie Ginnamon.
15 Birthplace Md.

16 (a) Informant Stanley L. Snouffer.
(b) Address 412 W 29th St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Nov. 24, 48 (month) (day) (year)
(c) Cemetery or crematory St. Mary's.
Location Hampden.

18 (a) Funeral director Paul E. Chenoweth Jr.
(b) Address 3615-17 Cheatnut Ave,

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Nov 22 1948.
and that I last saw h[illegible] alive on Nov 21, 1948.

Immediate cause of death: Carcinoma of Prostate — Duration: 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature A. Wesley Mc[illegible] M. D.
Address 2902 Huntingdon Ave Date signed 11-23-48

VS 150

668843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

668843 Registered No.

B.C.H-00138

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1103-Park Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GARFIELD DICKERSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1944

8. AGE: Years	Months	Days	If less than one day
4	11 6	15	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Otis Dickerson
13. Birthplace S.C.

MOTHER
14. Maiden Name Josephine Wardell
15. Birthplace Va.

16 (a) Informant Josephine Dickerson
(b) Address 425 Heaver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. HALSTEAD
(b) Address 918 Druid Hill Ave.

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 15.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1948 19 at 7:42 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull with intracranial hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing X cause of death, fill in the following: 12/5
(a) Date of injury Nov. 20, '48 approx. 7:10 P.M.
(b) Where did injury occur? Greenmount & North Ave.
(c) Did injury occur at home, on farm, industrial place, or public place) Public While at work? No
(d) Means of injury Ped. struck by auto

23. Signature [signature] M.D.
Medical Examiner
Date signed 11/24/48

6688:4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 6688:4

B- 124606

Type or print in ink. Do not write over printed letters. Use black ink. Do not use pencil. Be sure the entries are complete and legible.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 25

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2415 Paca St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Laura Brisco

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife? 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 30- 1880

8. AGE: Years	Months	Days	If less than one day
67	10	17	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER

12. Name Butler Lambert (D

13. Birthplace Md.

MOTHER

14. Maiden Name Mary Greene (D

15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School NOV 23 1948

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Entered for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1948 at 10.55 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 11-15- 1948 to 11-16- 1948, and that I last saw her alive on 11-16- 1948

Immediate cause of death: cardiac arrest - hemorrhage ?

Due to: Pos. Pul. embolus

Due to: ? for accident

Duration: 2 min

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M. F. Nelson M.D.

Address BCH Date signed 11-22-48

VS 150

68845 VL - 124437

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

952

68845 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 916 N. Central Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Anderson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 25, 1906

8. AGE: Years	Months	Days	If less than one day
42	4	17	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Belle Watkins
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 23 1948
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1948 at 5 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1948 to Nov. 12 1948. and that I last saw h er alive on Nov. 12 1948

Immediate cause of death	Duration
Uremia	
Due to (a) Rheumatic Heart Disease	
Due to (b) Nephritic Syndrome	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. T. Nelson M. D.
Address BCH Date signed 11-22

VS 150

688346

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

688346
Registered No. 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1207 William St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 William St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Frank T. Lindung

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gertrude F. Lindung
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Dec. 18-1881

8. AGE: Years	Months	Days	If less than one day
66	11	4	..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Police Captain
11. Industry or business Retired

FATHER
12. Name Conrad Lindung
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Matter
15. Birthplace Germany

16 (a) Informant Gertrude F. Lindung
(b) Address 1207 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26-48 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Cross Cem.
Location

18 (a) Funeral director Elizabeth Hafle Fun.
(b) Address 115 E. West St.

19 (a) NOV 24 1948 (Date rec'd by Reg.) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1948 at 11 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1948 to Nov 22 1948, and that I last saw h[illegible] alive on Nov 22 1948.

Immediate cause of death Arteriosclerosis Thrombosis

Due to

Due to

Other Conditions Contributing to Death but not related to Immediate Cause Given Above (Include pregnancy within 3 months of death) Gangrene Lt. leg

Date of operation —
Major findings of operation: —
of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify which place)
(e) Means of injury —

23. Signature John A. Schmuck, M.D.
Address 1307 S. Charles St. Date signed 11/23/48

V3 150

68847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 512

Registered No. G68847

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 725 S. Glover Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 S. Glover Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank C. Zielski

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-9514

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Julia
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) May 2, 1870

8. AGE: Years	Months	Days	If less than one day
78	6	21	..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Walenty Zielski
13. Birthplace Poland

MOTHER
14. Maiden Name Marcianna ?
15. Birthplace Poland

16 (a) Informant Mrs Julia Zielski
(b) Address 723 S. Glover Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore Co, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 NOV 24 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23rd 1948 at 9 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8th 1948 to Nov. 23 1948, and that I last saw h alive on Nov. 22 1948.

Immediate cause of death: Carcinoma of Prostate metastasis to Pulmonary — Duration: 6 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 1 yr ago + 1 yr ago
Major findings of operation Prostatectomy (malignancy) + Pneumonectomy 1 yr ago
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. S. Lyons M. D.
Address 733½ Patterson Pk Pa Date signed 11-23-48

VS 150

G68848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68848

121a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT & RUTLAND AVE
(c) Hospital or institution:
SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town DUNDALK (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 BRONDSHIP RD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS SCHULER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: MARY SCHULER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 16, 1865

8. AGE: Years 83 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation

11. Industry or business RET. BALTO. TRANSIT

FATHER
12. Name —
13. Birthplace

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant MRS. FRED J. THOMAS
(b) Address 19 BRONDSHIP RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 26, 1948 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location 7225 EASTERN BLVD.

18 (a) Funeral director Roland L Fuhrer
(b) Address 2112 DUNDALK AVE.

19 NOV 24 1948 (Date filed by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1948 at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 1948 to 11/23 1948 and that I last saw him alive on 11/23 1948

Immediate cause of death Cardio-Respiratory Failure — Duration 24 Hrs.
due to Uremia
Due to Nephrosclerosis
Due to Kidney shut down
Other Conditions A.S.C.V.D. & coronary insufficiency & arrhythmia
(Include pregnancy within 3 months of death)
Date of operation 11/18/48
Major findings of operation: Gangrene of right leg
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Summa M.D.
Address Sinai Hospital Date signed 11/23/48

VS 150

668849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/2

668849 Registered No.

LCH 120143

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos. 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 Ashland Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME BEATRICE PUCKETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/12/27

8. AGE: Years	Months	Days	If less than one day
21	9	11	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wade Puckett
13. Birthplace S. C.

MOTHER
14. Maiden Name Julia Fedd
15. Birthplace S. C.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 27 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Anne Arundel County Md

18 (a) Funeral director Mrs Lottie Frost
(b) Address 1408 Ashland ave

19 (a) NOV 24 1948 (Date received by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23/48 19 , at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2/48 19 to 11/23/48 19 ,
and that I last saw her alive on 11/23/48 19

	Duration
Immediate cause of death For advanced bilateral pulmonary tuberculosis	8 months
Due to	
Due to	
Other Conditions Tuberculosis enteritis tuberculosis pleura liver (Include pregnancy within 3 months of death)	3 months

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret A Morgan M D
Address Baltimore City Hosp Date signed 11-23-48

VS 150

68850 BC-48-25361

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

68850 Registered No.

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Green Sts

(c) Hospital or institution: University Hospital 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 403 North Mount St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Baby girl Boozer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/5/48

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Charles Boozer

13. Birthplace Baltimore Maryland

MOTHER 14. Maiden Name Martha Roundtree

15. Birthplace Baltimore Maryland

16 (a) Informant Charles Boozer

(b) Address 403 North Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 24, 1948 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn Cemetery

Location Baltimore Maryland

18 (a) Funeral director Joseph A. Lively

(b) Address 640 West Lanvale Street

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1948, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 1948 to 11-22 1948, and that I last saw her alive on 11-22 1948.

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ann Stonum M.D.

Address University Hospital Date signed 11-23-48

VS 153

G68851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 62B

Registered No. G68851

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 224 N. Payson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 224 N. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE ANN TRACY

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Noah O. Tracy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1880

8. AGE: Years 68 | Months 8 | Days 9 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William G. Holmes
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary E. Tucker
15. Birthplace Balto., Md.

16 (a) Informant Mr. Noah O. Tracy
(b) Address 224 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1948 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to Nov 23 1948 and that I last saw h[illegible] alive on Nov 18 1948.

Immediate cause of death: Cardiac failure — Duration: 1947
Due to: Hypertension — 1944
Due to:
Other Conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence A. Lena M.D.
Address 11 E. Chase St. Date signed 11/25/48

VS 150

6688:52

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a ✓

6688:52 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 Woodington Rd.
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Woodington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA E. GALE

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 14, 1865

8. AGE: Years	Months	Days	If less than one day
83	1	8	hr. min.

9. Birthplace Kent Co., Md.
(Town, county, and state)

10. Usual Occupation Retired Saleslady

11. Industry or business

FATHER
12. Name Isaac Gale
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Jane Enos
15. Birthplace Del.

16 (a) Informant Mrs. Thomas W. Gale
(b) Address 606 Woodington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948 at 8:00a M

21. I certify that death occurred on the date above stated: that I attended deceased from Oct 26 1948 to Nov 22 1948 and that I last saw her alive on Nov 22 1948

Immediate cause of death Coronary Occlusion — Duration 4 mos.

Due to

Due to

Other Conditions
(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. P. VonSchultzmd M. D.
Address 4818 Edmondson Date signed 11/23/1948

VE 150

VonSchultz. and ×

6688 Hal 7

B.C.H-50196

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54a

Registered No. 66853

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5427 Tynview Ave (If rural give location)
(e) Citizen of foreign country no (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Wayne Dusich

3 (b) If veteran, name war -
3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-21-46

8. AGE: Years	Months	Days	If less than one day
2	5	2	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation -none
11. Industry or business

FATHER
12. Name Paul Dusich
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mildred McCastle
15. Birthplace Hagerstown, Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23- 1948, at 1:15 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18- 1948 to 11-23 1948, and that I last saw him alive on 11-23 1948.

Immediate cause of death
Brain tumor — Duration
Due to Medulloblastoma of
Due to Cerebellum
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 11/20/48
Major findings of operation: Medulloblastoma of
of autopsy: Cerebellum

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Maurice Dieter
Address Johns Hopkins Date signed 11/23/48 M D

VS 153

Maurice P. Dieter X

G688:4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 C

Registered No. G688:4

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2871 W. Lafayette Ave.
(c) Hospital or institution: H-C

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2871 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CECIL E. BAILEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Marie Bailey — 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1884

8. AGE: Years	Months	Days	If less than one day
64	4	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business A. S. Abell Co.

FATHER
12. Name Benjamin W. Bailey
13. Birthplace Virginia

MOTHER
14. Maiden Name Rose Cherry
15. Birthplace Virginia

16 (a) Informant Mrs. Marie Bailey
(b) Address 2871 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948 at 1:32a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1947 to 11/22 1948. and that I last saw h[illegible] alive on 11/24 1948

Immediate cause of death Carcinoma of the Prostate & generalized Metastases — Duration 20 mos.

Due to

Due to

Other Conditions Hypertensive Cardio Vascular Disease — 4 years
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury W. Grafton Thompson

23. Signature W. Grafton Thompson M. D.
Address 21 W Madison St Balto Date signed 11/24/48

VS 150

G688:5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G688:5

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 162
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY RAYFIELD ADAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Seperated from wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1903

8. AGE: Years	Months	Days	If less than one day
44	11	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Fruit Handler

11. Industry or business

MOTHER | FATHER

12. Name James Adams

13. Birthplace New Jersey

14. Maiden Name Lillian Adams

15. Birthplace Back River, Md.

16 (a) Informant Edith Truman

(b) Address 1236 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)

(c) Cemetery or crematory St Stevens Cem

Location Back River Road Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1001 Bloomingdale Rd

19 (a) NOV 24 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1948 at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [x], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl Rogers M.D. Medical Examiner.

Date signed 11/22/48

VS 151

G688:56

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G688:56

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 515 N. Calvert St

(c) Hospital or institution:

5-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 515 N. Calvert St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Thomas Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6-1897

8. AGE: Years 51 | Months 8 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Handy Man

11. Industry or business

FATHER 12. Name Thomas Price

FATHER 13. Birthplace unknown

MOTHER 14. Maiden Name Annie Howard

MOTHER 15. Birthplace Gloucester Co. Md

16 (a) Informant Gertrude Brooks

(b) Address 515 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24-48 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Brooklyn Md

18 (a) Funeral director Elroy D. Wilson

(b) Address 1500 Baltimore ave

19 (a) NOV 24 1948 (Date rec'd by registrar) Hunter Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21st 1948, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1948, to Nov 21 1948, and that I last saw h[illegible] alive on Nov. 21st 1948.

Immediate cause of death: Heart failure — Duration

Due to Pulmonary Edema

Due to Hypertensive C.V.D. disease.

Other Conditions

(Include pregnancy within 3 mos. of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harris A. Pine M. D.

Address 118 Biscayne Date signed 11/23/48

VS 150

Harris A. Pine

688.57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 16688.57

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town BA RELAY (If outside city or town limits, write RURAL and give town)
(d) Street No. 4923 CEDAR AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES C. BULL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of ~~husband or~~ wife MARY D. CLARK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 19 1878

8. AGE: Years	Months	Days	If less than one day
70	3	3	hr. min.

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation
11. Industry or business B & O. R.R.

FATHER
12. Name ALFRED F. BULL
13. Birthplace MD.

MOTHER
14. Maiden Name ANNIE SIMPSON
15. Birthplace VA.

16 (a) Informant MRS MARY D. CLARK
(b) Address 4923 CEDAR AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 25 '48 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDRICK AVE

18 (a) Funeral director Harry A Wright
(b) Address 4101 Edmondson Ave

19 NOV 24 1948 (Date filed by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 22 1948 at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1948 to 11-22 1948, and that I last saw him alive on 11-22 1948.

Immediate cause of death: cardiac failure — Duration

Due to acute myocardial infarction

Due to acute coronary thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work) (Specify type of place)
(e) Means of injury

23. Signature John White M.D.
Address University Hosp. Date signed 11-22-48

VS 150

6688:38

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6688:38

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town rural ~~Big Spring~~ (If outside city or town limits, write RURAL and give town)
(d) Street No. Big Spring (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Boyd Isabelle Fay

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1932

8. AGE: Years 16 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation student

11. Industry or business

FATHER 12. Name William Boyd

13. Birthplace Washington County, Md

MOTHER 14. Maiden Name Ella Bonsi

15. Birthplace Washington Co., Md

16 (a) Informant William Boyd.

(b) Address Big Spring Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26, 1948 (month) (day) (year)

(c) Cemetery or crematory St. Paul's Cemetery

Location Clear Spring, Maryland

18 (a) Funeral director Snyder-Rowland

(b) Address Clear Spring, Maryland

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~November~~ Nov 23 1948, at 3:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/6 1948, to 11/23/48.
and that I last saw her alive on Oct 23 1948.

Immediate cause of death: cardio-respiratory failure — Duration

Due to

Due to acute myeloid leukemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isabelle Boyd M. D.

Address Univ. Hospital Date signed 11/23/48

VS (5)

6688:39

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6688:39

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Magothy
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

FULL NAME Elias (Elijah) Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1861

8. AGE: Years	Months	Days	If less than one day
67 yrs. ?			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Beach-Comber

11. Industry or business

FATHER 12. Name Andrew Jackson

13. Birthplace Md ?

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Mildred Owens

(b) Address 770 George St (Daughter)

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Magothy

Location

18 (a) Funeral director Williams & Jackson

(b) Address 916 Penna Ave

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22-48 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1948 to 11-22 1948 and that I last saw h[illegible] alive on 11-22 1948

Immediate cause of death	Duration
Respiratory Failure	
Due to Subarachnoid Hem.	
Due to Hypertension, Arteriosclerosis Cerebrovascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Hahn M. D.

Address University Hospital Date signed 11-22-48

68860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

68860

Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any person who wilfully supplies false information should be carefully supplied. The

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1717 Eyer St

(c) Hospital or institution:

24

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md, (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1717 Eyer St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Jane E. Buchanan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Widow

6 (b) Name of husband or wife Charles F. Buchanan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2/8/1858

8. AGE: Years	Months	Days	If less than one day
90	9	15	hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name James Lyons

13. Birthplace Ireland

MOTHER

14. Maiden Name Jane Poins

15. Birthplace Chicago

16 (a) Informant Mr John Buchanan

(b) Address 1717 Eyer St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Druid Hill Ave

18 (a) Funeral director J. J. Fahey & Sons

(b) Address 1818 Light St

19 (a) NOV 24 1948 (Date received by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1948, at 7A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1947 to Nov 22 1948. and that I last saw h alive on Nov 22 1948

Immediate cause of death	Duration
Asthenia nervosa	
Myocarditis.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Dr. S. Bauman

Address 436 E Fortune Date signed 11/24/48 M. D.

668861 ✓ 668861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 N. Front St.
(c) Hospital or institution:
5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County /
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 221 N. Front St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Massimo or Samuel Matricciani

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-0392

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ wife Teresa Matricciani
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22 1883

8. AGE: Years	Months	Days	If less than one day
65	1	-	hr. min.

9. Birthplace Atri Teramo Italy
(Town, county, and state)
10. Usual Occupation Forman
11. Industry or business

FATHER
12. Name Francesco Matricciani
13. Birthplace Italy

MOTHER
14. Maiden Name Serafina Lattanzi
15. Birthplace Italy

16 (a) Informant Teresa Matricciani (Wife)
(b) Address 221 N. Front St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 322 S. High St.

NOV 24 1948 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22 1948 at 2.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/9 1948 to 11/19 1948.
and that I last saw him alive on 11/19 1948.

Immediate cause of death Carcinoma rectum.

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 7/9/47

Major findings of operation: Carcinoma rectum with generalized metastasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be assigned statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Battaglia M. D.
Address 5 & 2 Belair Rd Date signed 11/24/48

VS 150

G68862

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G68862

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 N. Bentalou St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gabriel F. Schucker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	6 (b) Name of husband or wife	6 (c) If alive, give age
Male	White	Married	Carrie B. Schucker	68 years

7. Birth date of deceased (mo., day, yr.) March 11, 1871

8. AGE: Years	Months	Days	If less than one day
77	8	12	hr. min.

9. Birthplace Clearfield County, Pa. (Town, county, and state)
10. Usual Occupation Retired Construction & Maintenance
11. Industry or business Postal Telegraph

FATHER
12. Name Henry Schucker
13. Birthplace Clearfield County, Pa.

MOTHER
14. Maiden Name Susanne Aurand
15. Birthplace Clearfield County, Pa.

16 (a) Informant Mrs. G. F. Schucker
(b) Address 1101 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26, 1948 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cemetery
Location Elkridge, Md.

18 (a) Funeral director J. Willis Lamoreaux
(b) Address 4510 Liberty Heights Ave.

NOV 24 1948 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1948, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19-46 19 to 11-23-48 19 and that I last saw him alive on 11-23-48 19

Immediate cause of death: Myocardial failure — Duration 2 wks
Due to Arteriosclerotic Heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry S Gould M. D.
Address 2707 Brandon Ave. Date signed 11-23-48

VS 150

668863

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

668863 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 Harlem Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES MORGAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-4620

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucy Morgan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Charles Morgan
13. Birthplace: Va.

MOTHER
14. Maiden Name: Emma Harris
15. Birthplace: Va.

16 (a) Informant: Lucy Morgan
(b) Address: 711 Appleton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24/48 (month) (day) (year)
(c) Cemetery or crematory Not Claiming
Location L A Co. Mag

18 (a) Funeral director Isaac L Brown Son
(b) Address 1510 Druid Hill Ave

19 (a) Nov 24 1948 (b) Filed by registrar Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1948, at 2.55 AM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. Medical Examiner
Date signed 11-22-48

VS 151

G688b4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1178

Registered No. G688b4

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway at Fairmont
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 74
(e) Length of stay in Baltimore (yrs., mos., or days) 48yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2919 Woodland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Hannie H. Bayly

3 (b) If veteran, name war: No

3 (c) Social Security Account No. [illegible]7235

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Wh. Fe	Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12/30/85

8. AGE: Years	Months	Days	If less than one day hr.	min.
62	10	24		

9. Birthplace Gettysburg Pa. (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business

FATHER
12. Name Samuel Russell Bayly
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Margaret Major
15. Birthplace Pennsylvania

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-1948 (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Gettysburg Pa

18 (a) Funeral director J. Howard Strong
(b) Address 3207 St. North Ave

19 (a) NOV 24 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1948, at 12 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1948, to Nov 23 1948, and that I last saw him alive on Nov. 23 1948.

Immediate cause of death	Duration
Generalized Peritonitis	5 days
Anuria	
Due to Perforation Small Bowel	5 days
Due to	
Other Conditions Chronic Duodenal Ulcer	

(Include pregnancy within 3 months of death)

Date of operation 10/27/48; 11/1/48; 11/8/48 + 11/13/48
Major findings of operation: Duodenal Ulcer + Adhesions (Postoperative)
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard M. Garrett
Address Church Home + Hosp Date signed 23 Nov 48

VS 159

X

68865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 68865

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 13-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 Lake Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louis S. Goldbloom (Louis S. Goldbloom)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Pearl B. Goldbloom
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26 1876

8. AGE: Years 71 | Months 10 | Days 29 | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Store Prop.

11. Industry or business

FATHER
12. Name Herschel Goldbloom
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie ?
15. Birthplace Russia

16 (a) Informant Mrs. Herbert Goldbloom
(b) Address 729 Lake Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/48 (month) (day) (year)
(c) Cemetery Ohel Shalom
Location Balto. Md.

18 (a) Funeral director Blair Sonnheim & Son
(b) Address 1902 Eutaw Place

19 (a) (Date received by registrar) (b) Huntington Williams, Registrar

NOV 24 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23/48 19 . at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20/48 19 . to 11/23 19 48. and that I last saw him alive on 11/23/48 19

Immediate cause of death: Myocardial Infarct — Duration

Due to: Coronary art. Dis.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Myocardial Infarct

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lee N. Kastran

Address 300 N. Milton Date signed 11/23

G68866 **BALTIMORE CITY HEALTH DEPARTMENT**

CERTIFICATE OF DEATH

Registration No. 26886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4407 Old York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4407 Old York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Reed Hall

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-2449

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1890

8. AGE: Years	Months	Days	If less than one day: hr.	min.
58	6	12		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Electrician Inn Office
11. Industry or business

FATHER
12. Name Charles Hall
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Henretta Mullen
15. Birthplace Germany

16 (a) Informant Anna Hall
(b) Address 4407 Old York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-48 (month) (day) (year)
(c) Cemetery or crematory Oakland
Location Eastern Ave

18 (a) Funeral director John C Moran
(b) Address 3060 E Baltimore St

NOV 24 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1948 at 4:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1948 to Nov. 22 1948, and that I last saw him alive on Nov. 22 1948.

Immediate cause of death	Duration
Pulmonary Edema	1 hrs.
Due to Chronic Myocarditis	Yrs
Due to	
Other Conditions Hypertension	Yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Meeks M.D.
Address 6014 York Road Date signed 11-23-48.

VS 150

66887 ✓ 66887

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 921

Registered No. .....

66887

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md and Town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 Mulberry Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth Tomlinson Tomlinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Thomas Tomlinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 31, 1889

8. AGE: Years	Months	Days	If less than one day
58 59	10	23	hr. min.

9. Birthplace Maryland, Balto.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Thomas Hogan
13. Birthplace New York

MOTHER
14. Maiden Name Rose Ida Fleming
15. Birthplace Cambridge Md.

16 (a) Informant Mrs Mary Smith
(b) Address 212 Mulberry Rd.

17 (a) Burial (b) Date thereof 11-26-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John A. Moran
(b) Address 3006 E. Baltimore St

19 (a) NOV 1 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23 1948, at 12 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1948 to 11-23 1948, and that I last saw h[illegible] alive on 11-23 1948.

Immediate cause of death Subarachnoid Hemorrhage — Duration 6 hrs.

Due to Hypertensive CVD — 2.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Jr. M. D.
Address Mercy Hosp Date signed 11-23-48

VS 150

G688o8

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G688o8
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 828 Hollins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 Hollins St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Antanas Lauciatis (Lauciaitis)

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 217-03-5433

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr) Feb-11-1889

8. AGE: Years 59 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Baltimore Coat makers

FATHER
12. Name Jolyn
13. Birthplace Lithuania

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Anna Lauciatis
(b) Address 828 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-28 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Charles W Fackenthal
(b) Address 703 McHenry St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

NOV 24 1928

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22-28 19 . at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-28 19 . to 11-22-28 19 , and that I last saw h/m alive on 11-22-28 .

Immediate cause of death Terminal Bronchopneumonia bil.

Due to General Arteriosclerosis

Due to Cerebral Arteriosclerosis

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. O. Lange M. D.
Address 642 N. Gay St. Date signed 11-24-28

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68869 ✓ G68869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Charter Oak Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY OSBORNE MURROW

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Shubal E. Murrow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1879

8. AGE: Years	Months	Days	If less than one day
69	7	26	hr. min

9. Birthplace Greensboro, N.C. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Daniel Osborne
13. Birthplace North Carolina

MOTHER
14. Maiden Name Adele Stevens
15. Birthplace North Carolina

16 (a) Informant Mrs. John Pilling (Daughter)
(b) Address Be 4275 3391 Winston Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 24, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location Greensboro N. C.

18 (a) Funeral director Henry W. Jenkins & Son Co.
(b) Address 4905 York Rd. Huntington Williams, Mgr.

19 (a) 1948 (Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1948, at 5.50a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Traumatic pneumothorax left

Due to Fracture of Rib, left

Other Conditions Rupture of spleen

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 27/10

(a) Date of injury 11-13-48 at approx. 11.45 a. M.
(b) Where did injury occur? York Rd. & Richwood Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed November 23, 1948

68870 CERTIFICATE CORRECTED 9-1-50 68870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. .....

LCH - 123629

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month & 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 27 N. Carey Street (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country .....

3 (a) FULL NAME IDA GETTS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1880 1880

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68				

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER — 12. Name Leroy Getts

13. Birthplace Pa.

MOTHER — 14. Maiden Name Kathryn Bobendorf

15. Birthplace Pa.

16 (a) Informant B.C.H. records

(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)

(c) Cemetery or crematory Forest Hill

Location Timmonium, Md.

18 (a) Funeral director Wm Cook Jr.

(b) Address 1217 St Paul St.

19 (a) 1948 (b) [illegible] Registrar

24 (Date rec'd by registrar) Washington Avenue, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24/48 19 at 2:30 AM. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10/48 19 to 11/24/48 19 and that I last saw her alive on 11/24/48 19

Immediate cause of death Bronchopneumonia — Duration 2 days.

Due to .....

Due to .....

Other Conditions pyelonephritis with uremia. — 2 weeks.

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury .....

23. Signature John E. Beckstoll

Address Balto City Hosp. Date signed 11-27-48 M. D.

107

G68871

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G68871 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 Holbrook Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 Holbrook Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. Magrogan

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: ?

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John G. Magrogan
6 (c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1912

8. AGE: Years: 35 | Months: II | Days: 20 | If less than one day: ########## min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: James M. O'Connor
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Elizabeth Roche
15. Birthplace: Ireland

16 (a) Informant: Mr. John G. Magrogan
(b) Address: 1632 Holbrook Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: II/26/48 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cemetery
Location: Edmondson Avenue, Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) Nov 24 1948 (b)
(Registrar's signature) Registrar
Washington Hollinsworth, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 22 1948 at 11 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1947 to Nov 22 1948.
and that I last saw [illegible] alive on Nov 22 1948.

Immediate cause of death: Carcinoma of left breast — Duration: 2 yrs

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation: June 22, 47.
Major findings of operation: Carcinoma of left breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: W. H. Grainger, M.D.
Address: 1402 E. Lanvale St. Date signed: 11 23 48

Dr. Feinglas 68872 2002 E. Pratt St

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 9-27

Registered No. G 68872

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2402 Foster Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 Foster avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) if yes, name country

3 (a) **FULL NAME** Rosalia Sidlak Also spelled Siedlok, Seidlo and Sidlock

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1871

8. AGE: Years	Months	Days	If less than one day hr.	min
77	6	12		

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Joseph Fisher
13. Birthplace Poland

MOTHER
14. Maiden Name Lena
15. Birthplace Poland

16 (a) Informant Mrs. Theresa Tessler
(b) Address 614 S. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) 1948 (Date rec'd by registrar) (b) Registrar Huntington Williams

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24th 1946 at 5:40 AM

21. I certify that death occurred on the date above stated, that I attended deceased from [illegible] 1946 to [illegible] 1946, and that I last saw her alive on Dec. 3 1946.

Immediate cause of death: Acute Cardio-Vascular decompensation
Due to: Thrombo-endocarditis? Chr. Arteriosclerosis
Due to
Other Conditions C.P.C. Lungs
(Include pregnancy within 3 months of death)

Duration: acute ?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Israel Feinglas
Address 700 E. Pratt St. Date signed 11/27/46

M.D.

NFH

Penalty for wilfully making a false statement in regard to any of the above particulars is imprisonment for not more than one year or fine of not more than $500 or both.

Physicians: please write the causes of death clearly and legibly. The accuracy of this certificate is especially important.

G68873 ✓ G68873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 353 Rosebank Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3333 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Bayne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Katherine Frazier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 18, 1870

8. AGE: Years	Months	Days	If less than one day
78	1	5	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation clerk
11. Industry or business McPherson's Men's Furnish.

FATHER
12. Name Benjamin C. Bayne
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Frances Carey
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. G. Parker McPherson
(b) Address 3333 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery ~~Cemetery~~ Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John C. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) 1948 (Date rec'd by registrar) Wellington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1948 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1948 to Nov 23 1948 and that I last saw h[illegible] alive on Nov 23 1948

Immediate cause of death	Duration
Coronary occlusion	months
Due to Arteriosclerotic condition	1 yr
Due to Cerebral accident	1 yr ago
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation no
Major findings of operation: no
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Keyser M. D.
Address Wentworth Arms Apts. Date signed Nov 24 1948

VS 180

G68874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68874
Registered No.

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Dixie Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nicholas Cockey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Grace Rowe
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr) Dec 15 1873

8. AGE: Years	Months	Days	If less than one day
75	1	9	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Farmer
11. Industry or business Retired

FATHER
12. Name John Cockey
13. Birthplace Baltimore County Md

MOTHER
14. Maiden Name Anna Mitchell
15. Birthplace Maryland

16 (a) Informant Mrs. Grace R. Cockey
(b) Address 2 Dixie Drive Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory St. James Cemy.
Location The Manor, Balto. Co. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) 11-24 1948 (Date rec'd by registrar) (b) [illegible] for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 11/24 1948, at 7.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1948, to 11/24 1948.
and that I last saw him alive on 11/24 1948.

Immediate cause of death — Cardiac failure — Coronary sclerosis
Due to Accidental Pneumonia
Due to Heart Disease

Duration

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr Montes M. D.
Address Church Home Date signed 11/24/48

VS 151

G68875 ✓ G68875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

Write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Eutaw Place
(c) Hospital or institution: none 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma V. Jones Stoddard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife J. William Stoddard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) February 23, 1867

8. AGE: Years 81 | Months 9 | Days --- | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Alexander Jones
13. Birthplace St. Mary's County, Md.

MOTHER
14. Maiden Name Isabella C. Shaw
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Anita Johnston
(b) Address 1639 Gwynns Falls Parkway

17 (a) Burial (b) Date thereof 11/26/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Greenmount
Location Greenmount Ave. & Oliver St.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place, Baltimore

19 (a) 11-24 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1948 at 5 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 1941 to Nov 23 1948, and that I last saw h[illegible] alive on Nov. 22 1948.

Immediate cause of death: Myocardial Infarction;

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration: Fatal

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams, M.D.

Address 1403 Park Avenue Date signed 11-24-48

6688 76 JL- 122915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13R

Registered No. 6688 76

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Henryton Sanitorium
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moses Goldring

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? ? ?

8. AGE: Years	Months	Days	If less than one day
35 ?			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Grant Goldring
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza ?
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-48 (month) (day) (year)
(c) Cemetery or crematory
Location Leonardtown, St Marys Co. Md.

18 (a) Funeral director Pius B. Robinson
(b) Address Dameron, St. Mary's Co., Md.

19 NOV 25 1948 Huntington Williams, M.D. Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1948, at 8.45 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1948 to Nov. 13 1948, and that I last saw him alive on Nov. 23 1948.

Immediate cause of death Respiratory failure — Duration

Due to Cachexia d/t Pulmonary tuberculosis with empyema

Due to

Other Conditions Dehydration, decubitus

(Include pregnancy within 3 months of death)

Date of operation 9/25/48, 11/16/48

Major findings of operation: Pulmonary tuberculosis

of autopsy: At times.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. P. Murphy M. D.
Address Balto. City Hosp. Date signed 11/25/48

VS 150

G68877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G68877

Type or print in ink. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
St. Joseph's Hospital 26-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4447 Belair Road (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Amelia Merz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe.	White	Married

6 (b) Name of husband or wife James Conrad Merz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1888

8. AGE: Years	Months	Days	If less than one day
59	11	27	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Hwfe.
11. Industry or business

FATHER
12. Name Frank Gruel
13. Birthplace Austria

MOTHER
14. Maiden Name Julia Simard
15. Birthplace Austria

16 (a) Informant Mr James Merz
(b) Address 4447 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Joa Patterson & Son
(b) Address 3001 Huntington Ave

19 NOV 25 1948 (Date filed by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1948, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22/ 1948 to 11/23/ 1948, and that I last saw her alive on 11/23/ 1948.

Immediate cause of death	Duration
Uremia	
Due to Chronic Nephritis	
Due to	
Other Conditions Diabetes Mellitus	

(include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Guy E Peterson Jr. M.D.
Address St. Joseph's Hosp. Date signed 11/23/48

12/12

VS 150

68878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 68878

Please print plainly, write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4613 Park Heights Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4613 ParkHeights Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Dora Millman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Unkown

13. Birthplace Russia

MOTHER

14. Maiden Name Unkown

15. Birthplace Russia

16 (a) Informant David A Millman

(b) Address 2228 Ruskin Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 25, 1948 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship Cem

Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

1948 NOV 25 1948 (b) Huntington Ave Reisterstown, Md.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1948 12.25 A. M
(19 , at M)

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25 1948 to 11/22 1948 and that I last saw h alive on 11/22 1948

Immediate cause of death	Duration
Gangrene Left Leg.	
Due to Infarction	
Due to Carcinoma of Liver	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature A. L. Homstein M. D.

Address 204 E. Biddle St Date signed 11/25/48

VS 150

068879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 068879

469

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Streets
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 318 days
(e) Length of stay in Baltimore (yrs., mos., or days) 318 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town CATONSVILLE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 FREDERICK ROAD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME OSCAR Bechtol Coblentz

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 215-09-5066

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife: Margaret Pontius Coblentz
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1878

8. AGE: Years	Months	Days	If less than one day
69	11	28	hr. min.

9. Birthplace Middletown, Maryland (Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business McLean-Combaugh Co

FATHER
12. Name Edward L. Coblentz
13. Birthplace Middletown, Maryland

MOTHER
14. Maiden Name Lucinda F. Bechtol
15. Birthplace Middletown, Maryland

16 (a) Informant Union Memorial Hosp. Records
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory Reformed Lutheran Cemetery
Location Middletown - Md.

18 (a) Funeral director Shiverts Mortuary
(b) Address Thurmont, Md.

19 NOV 25 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1948, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 10, 1948 to Nov 22 1948, and that I last saw him alive on Nov. 22, 1948.

Immediate cause of death	Duration
Carcinoma of Pancreas with metastasis to liver and retroperitoneal	
Due to lymph nodes.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Nov. 11, 1948
Major findings of operation: Umbilical hernia, Ascites, indurated pancreas, enlarged nodes
Findings of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J. Frank Shipley III
Address Union Memorial Hosp. Date signed 11/22/48

VS 150

668830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

668830 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4023 Wilkens Ave.
(c) Hospital or institution: 25-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4023 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country —

3 (a) FULL NAME Elizabeth Dein (Diem)

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Separated

6 (b) Name of husband or wife John Diem

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1868

8. AGE: Years 80 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

MOTHER / FATHER
12. Name John Zill
13. Birthplace Germany
14. Maiden Name Elizabeth ?
15. Birthplace Germany

16 (a) Informant Geo. Fuhrmann Jr.
(b) Address 202 S. Catherine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1948 at 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1944 to Nov 25 1948, and that I last saw her alive on Nov 14 1948

Immediate cause of death	Duration
Arteriosclerotic Heart disease with failure	4 yrs.
Due to Generalized Arteriosclerosis	4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Karl Fass, M.D.
Address 4007 Wilkens Ave Date signed 11-25-48 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68881 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2923 Ulman Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2923 Ulman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Israel Goldman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 68 | Months | Days | If less than one day: hr. min

9. Birthplace Russia (Town, County, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Aymar
13. Birthplace Russia

MOTHER 14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Mary Garnett
(b) Address 3572 White Chapel Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd. Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2600 Eutaw Place

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24- 1948, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1947 to 11/24 1948.
and that I last saw him alive on 11/24 1948.

Immediate cause of death	Duration
Acute cerebral Hemorrhage	
Due to Ch arteriosclerosis	
Due to Ch Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. H. Hometown
Address 204 E. Biddle St Date signed 11/24/48

VS 150

68882 B.C. 48-28902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157 M

Registered No. 68882

Type or print in ink. Fill all items. Write "None" where necessary. Sign the certificate of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5000 Elmer Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Shulman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr

8. AGE: Years | Months: | Days: 1 | If less than one day: hr min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Manuel Shulman
13. Birthplace Poland

MOTHER 14. Maiden Name Esther Rosenzweig
15. Birthplace Poland

16 (a) Informant Manuel Shulman
(b) Address 5000 Elmer Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Jack Keiser Inc

18 (a) Funeral director 2100 Eastern Place
(b) Address

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23, 1948, at 10 03 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 11/23 1948 to 11/23 1948, and that I last saw her alive on 11/23 1948.

Immediate cause of death: Osteogenesis Imperfecta Congenita with Fractured L & R Femora & Both Humeri — Duration

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan J. Wolinsky, M.D.
Address Sinai Hosp Date signed 11/24/48

VS 150

668883

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 668883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3706 Hortonia Rd
(c) Hospital or institution: The Mount Hope Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give township)
(d) Street No. 1701 No Fenteton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pete Shapiro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Fannie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day: hr	min
66				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Real Estate
11. Industry or business

FATHER
12. Name Solomon
13. Birthplace Russia

MOTHER
14. Maiden Name Meryam
15. Birthplace Russia

16 (a) Informant Fannie Shapiro
(b) Address 1701 No Fenteton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-48 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) NOV 25 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1948 at 7:9 M

21. I certify that death occurred on the date above stated, that I attended deceased from July 46 to Nov. 24 1948 and that I last saw him alive on Nov. 24 1948

Immediate cause of death: Myocarditis with fatal heart block.

Duration

Due to

Due to

Other Conditions: Hypertension & paralysis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Schapiro
Address 2028 Eutaw Place Date signed 11-24-48

VS 150

168884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462

Registered No. 168884

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Orchester Nursing Home
(c) Hospital or institution:
3520 Harford Rd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Harford
(c) City or town Edgewood md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Jennie May Preston

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25 1882

8. AGE: Years	Months	Days	If less than one day
66	6	0	hr. min.

9. Birthplace Harford Co md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Robert Preston
13. Birthplace Harford Co md

MOTHER
14. Maiden Name Anna Gerhardt
15. Birthplace Baltimore md

16. (a) Informant Mrs Edna Donnelly
(b) Address Edgewood md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27 1948 (month) (day) (year)
(c) Cemetery or crematory Babylon
Location Aberdeen md

18 (a) Funeral director Harry Tawney Ford
(b) Address Edgewood md

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1948, at 4.50 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1948, to Nov 25 1948, and that I last saw h[illegible] alive on Nov 24 1948.

Immediate cause of death	Duration
Cerebral Thrombosis	1 mo
Due to Senility (6 mo)	
Due to	
Other Conditions Generalized Arteriosclerosis	1 mo

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. H. D. Stevens M. D.
Address 2818 Harford Ave Date signed 11-25-48

V S 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

668885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106a

Registered No. 668885

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Street

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Carroll

(c) City or town Westminster Route #5
(If outside city or town limits, write RURAL and give town)

(d) Street No. Route #5
(If rural, give location)

(e) Citizen of foreign country? Ohio (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Sauat

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb, 1948

8. AGE: Years | Months 10 | Days | If less than one day hr. min.

9. Birthplace Westminster, Carroll, Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Kenneth Sauat

13. Birthplace Md.

MOTHER 14. Maiden Name Elsie Fritz

15. Birthplace Md.

16 (a) Informant Father

(b) Address Route #5 Westminster

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/48 (month) (day) (year)

(c) Cemetery or crematory Lutheran Cemetary

Location Union Mills Md

18 (a) Funeral director J. Harbaugh & Sons.

(b) Address Union Bridge & Needmore

19 (a) (b) Date filed by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1948, at 4:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1948, to Nov. 25 1948, and that I last saw him alive on Nov. 25 1948.

Immediate cause of death	Duration
~~Acute pneumonia~~ Acute respiratory failure	
Due to Acute laryngo-tracheo-bronchitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/24/48

Major findings of operation: Tracheotomy

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature J. L. Trenchard Jr.

Address University Hosp. Date signed M 11 D 26/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G68886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3800 Foster Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 Foster Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NICHOLAS ZINKAND

3 (b) If veteran, name war ----

3 (c) Social Security Account No. ----

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosa Zinkand

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr) Oct. 15, 1869.

8. AGE: Years 79 | Months 1 | Days 8 | If less than one day: hr. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation Retired.

11. Industry or business Baltimore City Worker.

FATHER
12. Name Nicholas Zinkand
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Ann Hartmann
15. Birthplace Germany

16 (a) Informant Rosa Zinkand (Widow)
(b) Address 3800 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Rd.

18 (a) Funeral director Charles S. Zailer.
(b) Address 901 S. Conkling St.

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1948 3:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1943 to Nov 23 1948, and that I last saw h alive on Nov 22 1948.

Immediate cause of death: Arteriosclerosis — Duration: 1943
Due to: Hypertensive Heart Disease — Nov 20 — 1948
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Heckmann M.D.
Address 3424 Bank St. Date signed Nov 24 48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668837

829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 413 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES HEYWARD TAYLOR

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 25, 1880

8. AGE: Years 68 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Self

FATHER
12. Name Winfield Taylor
13. Birthplace

MOTHER
14. Maiden Name Decima Heyward
15. Birthplace

16 (a) Informant Decema S. Heyward
(b) Address 662 Register Ave.,

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 11/27/48 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Waverly, Baltimore, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 NOV 25 1948 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24th 1948, at 12:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15th 1948, to Nov. 24th 1948, and that I last saw h in alive on Nov. 24th 1948.

Immediate cause of death
Cerebral Hemorrhage — Duration 1 day
Due to Arterio-Sclerosis — 2 days
Due to — Long
Other Conditions Pernicious anaemia — Long
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Jos Blalock, M.D.
Address 1200 N. Calvert St Date signed Nov. 24/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46 B

Registered No. 668838

668838

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Good Samaritan Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 838 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA RITTLE

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	None	Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 1889

8. AGE: Years	Months	Days	If less than one day
59	8		hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Rittle
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant David G. Weiland
(b) Address 2559 Kirk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/48 (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1948 19 . at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 19 48 to 11/24/48 19 , and that I last saw h alive on 11/23/48 19 .

Immediate cause of death Thyocardiac Stasis — Duration unknown

Due to Cancer Stomach — unknown

Due to Diabetes — "

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Thomas F. Corrigan, M.D.
Address 1012 Eastern Ave. Date signed 11/29/48

68889

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

939

Registered No. 68889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 West 34th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 Tudor Arms Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME KATHERINE F. STEIGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1859

8. AGE: Years	Months	Days	If less than one day
89	6	10	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Schoolteacher, retired
11. Industry or business

FATHER
12. Name Joseph Steiger
13. Birthplace

MOTHER
14. Maiden Name Elizabeth French
15. Birthplace Md

16 (a) Informant Mrs Clarence Boggs,
(b) Address 3705 Beech Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1948 19 , at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 19 48 to Nov 24 19 48 and that I last saw h[illegible] alive on Nov 23 19 48.

Immediate cause of death Myocardial infarct

Duration 1 mo.

Due to Arterio sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, industrial place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed Nov 24 1948

VS 150

8890 BC-48-25300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65350

160a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3447 South Balt. General

(c) Hospital or institution: 1213 Light Street Balt Maryland

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore Dundalk (If outside city or town limits, write RURAL and give town)

(d) Street No. 3117 Shortway Street (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Wesley D. Lurz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 20-48

8. AGE: Years | Months | Days 4 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Walter B. Lurz

13. Birthplace Balto Md

MOTHER 14. Maiden Name Fay Unthank

15. Birthplace Ky

16 (a) Informant Walter B. Lurz

(b) Address 3117 Shortway. Dundalk.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill Cem

Location Towson Balto Co

18 (a) Funeral director Wm Cook Inc.

(b) Address 1217 St Paul st

19 (a) (Date rec'd by registrar) (b) Signature for William M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 1948, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 19 48 to 11/24 19 48, and that I last saw h[illegible] alive on 11/24 19 48.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopay:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 11/25/48

VS 150

68891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. 68891

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 33 La CALVERT ST.
(b) Street address ~~Union Memorial Hospital~~
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2m 22d.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos 22d.

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town CHARLESTON (If outside city or town limits, write RURAL and give town)
(d) Street No. FRANCIS MARION HOTEL (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT T. ROSEMOND.

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M Rosemond

6 (b) Name of husband or wife LOUISE BRADSHAW
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) JUNE 23 1878

8. AGE: Years	Months	Days	If less than one day
70	5	2	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation HOTEL MANAGER.
11. Industry or business

FATHER
12. Name HENRY ROSEMOND.
13. Birthplace N.C.

MOTHER
14. Maiden Name DORA PALMER
15 Birthplace N.C.

16 (a) Informant Mrs Louise B. Rosemond
(b) Address Belvedere Hotel

17 (a) Removal (b) Date thereof 11/26/48 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenhill Cem
Location Greensboro N. C.

18 (a) Funeral director Wm Cook Inc
(b) Address 217 S. Paul St.

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) [illegible] Williamson, N.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-25- 19 48, at 11:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 3 19 48, to NOV 25 19 48, and that I last saw h.m alive on NOV 25 19 48.

Immediate cause of death Ca of stomach

Duration

Due to

Due to

Other Conditions ? menopause

(Include pregnancy within 3 months of death)

Date of operation 9-29-48

Major findings of operation: Ca of stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 11-26-48

VS 150

68892

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95B

Registered No. 68892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 3'
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 325 Herring Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB George MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1898

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Phila Pa (Town, county, and state)

10. Usual Occupation Shipper

11. Industry or business

FATHER
12. Name Semon
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Gertrude Miller
(b) Address 325 Herring Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)

(c) Cemetery or crematory
Location Newgrew Herring Run

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

NOV 25 1948 (Date rec'd by registrar) (b) Huntington Nat'l Bank Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 1948 at 10:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/1 1948 to 11/24 1948 and that I last saw him alive on 11/24 1948.

Immediate cause of death Uremia
Pulmonary Edema
Pulmonary Infarcts
Due to Rheumatic Heart Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Tepper M.D.
Address Sinai Hospital Date signed 11/25/48

VS 150

68893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. 668893

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 716 N. Montford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 N. Montford Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Christian W. Daub

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-6092

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sophie Daub

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12-1877

8. AGE: Years 71 | Months 7 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Levenson + Klein

FATHER
12. Name Ludwig Daub
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Kratz
15. Birthplace Balto. Md.

16 (a) Informant Sophie Daub
(b) Address 716 N. Montford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location North Ave + Gay St

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

NOV 25 1948 (Date rec'd by registrar) Washington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1948, at 3 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1941 to Nov. 23 1948. and that I last saw him alive on Nov. 23 1948.

Immediate cause of death: Cerebral Thrombosis — Duration: 5 days
Due to: Cerebral Arteriosclerosis
Due to: Cerebral Arteriosclerosis
Other Conditions: Hypertensive Heart Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frederick D. Cooke M.D.
Address 845 N. Patterson Pk. Date signed 11/24/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any false statement, omission or concealment of information should be carefully supplied.

BC-C-6153 ✓ 108 6688-14

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 Linden Ave
(c) Hospital or institution: 1st floor front

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Linden Ave 1st Front
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Anne Banks ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1944

8. AGE: Years 3 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William Banks
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Lee Spence
15. Birthplace Richmond County Va

16 (a) Informant Mary Lee Banks
(b) Address 1013 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory W. F. Calvary Cemetery
Location Cedar Hill

18 (a) Funeral director Stephen H. Halstead
(b) Address 918 Edmondson Ave

19 NOV 25 1948 (Date received by registrar) (b) Funeral for Williams Mt

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1948, at 1 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23-1948 to 11-23-1948, and that I last saw him alive on 11-23-1948.

Immediate cause of death Pulmonary Congestion — Duration

Due to Bilateral Lobar Pneumonia — 24 hrs

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1723 Druid Hill Ave Date signed

X 11-23-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 68895

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3708 E Pratt (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ULYSSES STANLEY KNOCHEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Beulah Knochel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 11 1889

8. AGE: Years	Months	Days	If less than one day
59	5	12	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Draftsman

11. Industry or business Md Dry Dock

FATHER
12. Name Conrad Knochel
13. Birthplace Ger

MOTHER
14. Maiden Name Margaret Gerhdsenzig
15. Birthplace Ger

16 (a) Informant Mrs Beulah Knochel
(b) Address 3708 E Pratt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27/48 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Balto

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1948, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23 1948 to 11-23 1948 and that I last saw h alive on 11-23 1948

Immediate cause of death	Duration
(a) Coronary thrombosis	
Due to (b) Myocardial infarct	
Due to (c) Coronary thrombosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Alfred Gerhdsenzig M.D.
Address University Hosp Date signed 11-23-48

VS 150

68896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. 68896

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3607 Kimble Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Kimble Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha A Tippett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar 24 1873

8. AGE: Years 75 | Months 7 | Days 29 | If less than one day hr. min

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Robert Tippett
13. Birthplace Eng

MOTHER
14. Maiden Name Mary Williams
15. Birthplace Wales

16 (a) Informant Mrs Carrie Zimmerman
(b) Address 3607 Kimble Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co Md

18 (a) Funeral director Wellwood Funeral Home
(b) Address 2008 Orleans

19 (a) (Date received by registrar) NOV 25 1948 (b) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1948 at 10 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 to Nov 23 1948
and that I last saw h alive on 11-29-48

Immediate cause of death Hypertensive Cardiovascular Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1 7

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred Ruzicka M. D.
Address Date signed 11-24-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Omission of information should be carefully supplied.

688897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. 688897

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Baltimore Sts.
(c) Hospital or institution:
Hotel Emerson

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore & Calvert Sts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM GOLDSMITH

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hattie V. Goldsmith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1870

8. AGE: Years 78 | Months 10 | Days 6 | If less than one day: hr. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Jacob Goldsmith
13. Birthplace Europe

MOTHER
14. Maiden Name Yetta ?
15. Birthplace Europe

16 (a) Informant Mrs. Hattie V. Goldsmith
(b) Address Hotel Emerson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1948 at 10:00 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 18 1948 to Nov 23 1948 and that I last saw him alive on Nov. 23 1948

Immediate cause of death: Arteriosclerosis, cerebral — Duration: 6 mos.

Due to

Due to

Other Conditions Arteriosclerotic heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Z. Rubenfeld M.D.
Address 1101 St. Paul St. Date signed Nov. 26, 48

VS 1/50

97

68898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. 68898

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 W. Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md, (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 423 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA VIRGINIA PRESTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1876

8. AGE: Years	Months	Days	If less than one day
71	10	29	Hr. min.

9. Birthplace Harford Co., Md. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Robert A. Preston
13. Birthplace Harford Co.

MOTHER
14. Maiden Name Sarah F. Rolls
15. Birthplace Harford Co.

16 (a) Informant Miss Flora E. Preston
(b) Address 248 W. Phila. St., York, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICHNER & SONS
(b) Address Balto., Md.

NOV 29 1948 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1948 at 7:45a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21, 1948 to Nov 23 1948, and that I last saw her alive on Nov 23 1948

Immediate cause of death	Duration
Right hemiplegia	
Due to Hypertension	
Due to	
Other Conditions Chr. Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hope E. Gammon M.D.
Address 720 Medical Arts Bldg Date signed Nov 24, 48

VS :50

68899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. 68899

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1737 E. 30th. Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1737 E. 30th. Street (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME EMMA LAVINIA COOPER (COOPER)

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles Carroll Cooper
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1877

8. AGE: Years	Months	Days	If less than one day
71	0	22	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Thomas Hammen
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Angenora Hughes
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Charles C. Cooper
(b) Address 1737 E. 30th. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) NOV 25 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 19 48 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 48 to 11-25 19 48
and that I last saw her alive on 11-23 19 48

Immediate cause of death INTESTINAL OBSTRUCTION — Duration 4 mos
Due to CANCER PANCREAS — 4 mos
Due to
Other Conditions THYROID ADENOMA
(Include pregnancy within 3 months of death)
Major findings: Of operations CA PANCREAS
Of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter E. Karlson M. D.
Address 4331 Harford Rd Date signed 11-27-48

VS 3

68900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 B

Registered No. 68900

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2821 Georgetown Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2821 Georgetown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Perry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mary Francis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 10-1875

8. AGE: Years	Months	Days	If less than one day
73	8	14	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Baker

11. Industry or business Pastry Bakery

FATHER
12. Name William H. Perry
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth Ash
15. Birthplace Baltimore Md

16 (a) Informant Mary Francis Perry
(b) Address 2821 Georgetown Rd

17 (a) Burial (b) Date thereof Nov 27-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Frederick Rd

18 (a) Funeral director Walter J. Schweinburg
(b) Address 1126 W. Cross St.

19 (a) NOV 25 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1-1948 to 11-24 1948 and that I last saw h alive on 11-24 1948

Immediate cause of death Acute Heart failure — Duration 1 day

Due to Carcinoma of Prostate

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 1948

Major findings of operation: Carcinoma of Prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Klan M.D.

Address 876 Woodbourne Ave Date signed 11/24/48

VS 150

68901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68901

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1115 Sarahann St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Sarahann St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLAUDE FLOYD

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10/8/1882

8. AGE: Years	Months	Days	If less than one day
66	1	15	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Junk Dealer

11. Industry or business

FATHER
12. Name -
13. Birthplace -

MOTHER
14. Maiden Name -
15. Birthplace

16 (a) Informant Sarah Thorton (Friend)
(b) Address 1115 Sarahann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) NOV 25 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 193

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1948, at 6:A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1948 to 11/23 1948, and that I last saw h[illegible] alive on 11/23 1948.

Immediate cause of death Cerebral vascular accident (Hemorrhage) — Duration 5 days

Due to

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm Garner
Address 253 Conway Date signed 11/27/48

X

68902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68902

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Sinia Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3805 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Twele

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lydia Twele
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1903

8. AGE: Years	Months	Days	If less than one day hr.	min.
45				

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Police Sgt.
11. Industry or business (retired)

FATHER
12. Name Frederick Twele
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary A Flaherty
15. Birthplace Baltimore

16 (a) Informant Mrs. Edward Twele
(b) Address 3805 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) NOV 25 1948 (Date rec'd by registrar) Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 19 48 at 6 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23 19 48 to 11/23 19 48, and that I last saw h[illegible] alive on 11/23 19 48

Immediate cause of death: A Hemorrhage Brain HT disease and coronary occlusion
Due to: & pulmonary edema
Due to:
Other Conditions: /

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M D
Address Sinai Hosp. Date signed 11/23/48

VS 150

BC-48-2514

68903

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. 68903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton Avenue
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City (If outside city limits or town limits, write RURAL and give town)
(d) Street No. 2 Orchard Drive Ellicott City (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Girl Lawson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 18, 1948

8. AGE: Years | Months | Days 7 | If less than one day hr min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Victor R. Lawson
13. Birthplace Md.

MOTHER
14. Maiden Name Ruby L. Hunter
15. Birthplace Md.

16 (a) Informant Hospital Records.
(b) Address St Agnes - Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-48 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Ellicott City Md

18 (a) Funeral director J. C. Hyneman & Son
(b) Address Ellicott City Md.

19 (a) NOV 25 1948 (b) Filed by registrar Nov 26 1948

Undertaker Williams, M.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25/48 19 .. at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18/48 19 .. to 11-25 19 48 and that I last saw h.. alive on 11-25 19 48.

Immediate cause of death Prematurity 32 wks.
Due to Cardio Resp failure
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

Duration

Date of operation .....
Major findings of operation: .....
.....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence A. O'Leia Jr. M.D.
Address St Agnes Hosp Date signed 11/26/48

VS 150

668904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 668904

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 194 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 324 E. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Williams, Hermie Hartfield

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife French Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 29, 1893

8. AGE	Years	Months	Days	If less than one day
	54	8	7	25 hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER 12. Name Howard Hartfield

13. Birthplace Benson, N. C.

MOTHER 14. Maiden Name Lucinda Streeter

15. Birthplace N. C.

16 (a) Informant French Williams.

(b) Address 324 East Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26, 1948 (month) (day) (year)

(c) Cemetery or crematory Arlington Memorial

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) Nov 25 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1948, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1948 to 11/23 1948, and that I last saw her alive on 11/23 1948.

Immediate cause of death	Duration
Secondary Shock	
Due to Cellulitis of Lumbar region	
Due to Diabetes Mellitus	
Other Conditions Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Marcus W. Moore Sr

Address Provident Hospital Date signed 11/25/48

VS 150

668905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 668905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2302 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 Washington Blvd (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Frank Martindale

3 (b) If veteran, name war none

3 (c) Social Security Account No. 217-12-5058

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lena Martindale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15-1875

8. AGE: Years 73 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Balto md (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Wood Workers

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Harriet ?
15. Birthplace ?

16 (a) Informant Lena Martindale
(b) Address 2302 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29-1948 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Balto Co Md

18 (a) Funeral director Edward Poulson
(b) Address 2359 Washington Blvd

19 (a) (Date received by registrar) NOV 25 1948 (b) Huntington Williams M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1948, at 11 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1948 to Nov. 25 1948, and that I last saw him alive on Nov. 25 1948.

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerotic C-V-D

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Clifton Rosenplatt M. D.
Address 2411 Wash. Blvd. Date signed 11/25/48

X

G68906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G68906

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1708 Eutaw St

(c) Hospital or institution: Elmhurst Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits write RURAL and give county)

(d) Street No. 2306 Sulgrave Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard M. MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1948, at 4:20 A M

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Bertha Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 21, 1868

8. AGE: Years 79 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county or state)

10. Usual Occupation Retired Plumber

11. Industry or business

FATHER 12. Name Stephen Miller

13. Birthplace Scotland

MOTHER 14. Maiden Name Mary J. Friedhofer

15. Birthplace Md

16 (a) Informant John L. Miller

(b) Address 2306 Sulgrave Rode

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27-1948 (month) (day) (year)

(c) Cemetery or crematory Laudon Park

Location Balto Md

18 (a) Funeral director Edward Tamburro

(b) Address 2359 Washington Blvd (Incorporated or Nilliacue, Md.)

19 (a) NOV 25 1948 (Date rec'd by registrar) Registrar

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1948 to Nov. 23 1948 and that I last saw h alive on Nov. 23 1948.

Immediate cause of death Generalized carcinomatosis

Due to Ca - Lower colon

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify which place)

(e) Means of injury

23. Signature Louis Jacobs M D

Address 1700 Eutaw Pl. Date signed 11-26-48

VS 150

G68907

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G68907
Registered No.

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1117 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) **FULL NAME** Frank Leo

3 (b) If veteran, name war
3 (c) Social Security Account No. 212-05-9245

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Maria Santa
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) [illegible] 1878
8. AGE: Years 70 | Months | Days | If less than one day hr. min.
9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business
FATHER 12. Name John Leo
FATHER 13. Birthplace Italy
MOTHER 14. Maiden Name Angela Pama
MOTHER 15. Birthplace Italy
16 (a) Informant Angeline Leo
(b) Address 1117 Poplar Grove Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-27-1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Road
18 (a) Funeral director Joseph Zarace Inc.
(b) Address 2[illegible]48 Greenmount Ave
19 (a) NOV 25 1948 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1948, at 4 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7, 1948 to Nov. 24, 1948, and that I last saw h alive on Nov. 24, 1948.

Immediate cause of death Arteriosclerotic Cardio-Vascular Disease with Cardiac Hypertrophy & Diabetis — Duration 3 mo.

Due to

Due to

Other Conditions Diabetis Mellitus — 12 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Kemmell. M.D.
Address Medical Arts Bldg Date signed 11/24/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

GGB908 B.C. # 2-28910

Hospital Dispensary 7-22-92

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. GGB908

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Kenneth Taylor

13. Birthplace ? ?

MOTHER 14. Maiden Name ? ?

15. Birthplace ? ?

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) NOV 25 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1948, at 1.25 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death: Congenital atelectasis

Due to

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. C. Parig M. D.

Address Johns Hopkins Hosp Date signed 11-15-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 68903

68903 BC-48-25499 161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 27 + 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 5803 Chinquapin Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Dunphy

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 16-1918

8. AGE: Years	Months	Days	If less than one day
—	—	4 2	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name Charles H. DunPhy
13. Birthplace

MOTHER
14. Maiden Name Shirley Gill
15 Birthplace

16 (a) Informant U. S. Md. Records
(b) Address Baltimore

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Disposed of by Hospital.

18 (a) Funeral director
(b) Address

19 (a) NOV 25 1918 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1918, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from November 17 1918 to November 19 1918, and that I last saw h[illegible] alive on November 19 1918

Immediate cause of death Anoxia

Due to: massive atelectasis

Due to Congenital state

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: massive atelectasis

Duration: 4 days (Present since birth)

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or public place? While at work?
(Specify)
(e) Means of injury

23. Signature Francis M. Grant M.D.
Address Union Memorial Hosp Date signed 11-19 18

VS 150

X

66890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

✓ Registered No. 66890

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson & Greene
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 Etting St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Parker

3 (b) If veteran, name war

3 (c) Social Security Account No 216-03-6825

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Naomi

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1899

8. AGE: Years 49 | Months 4 | Days 27 | If less than one day: hr. min.

9. Birthplace Cambill, Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name Herbert L. Parker

13. Birthplace Anne Arundel Co. Md.

MOTHER 14. Maiden Name Janie Johnson

15. Birthplace Anne Arundel Co. Md.

16 (a) Informant Mrs. Naomi Parker

(b) Address 2204 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/1948 (day) (year)

(c) Cemetery or crematory Arbutus Mem

Location Baltimore, Md.

18 (a) Funeral director George H. Copeland

(b) Address 1629 Druid Hill Ave.

19 (a) NOV 25 1948 (Date received by Registrar) (b) Kensington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24 1948 M

21. I certify that death occurred on the date above stated, that I attended deceased from 10-1-48 to 11-24-48 and that I last saw him alive on 11-24-48

Immediate cause of death	Duration
Metastic Carcinoma & Gastric Hemorrhage	
Due to Duodenal Ulcer	
Due to Carcinoma of Pancreas	
Other Conditions	

(If suicide, pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause for which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C Brightbower

Address University Hospital Date signed 11-25-48

Physicians: please write the causes of death clearly and legibly. Any erasures or alterations are especially important.

VS 150

068911

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1176

068911

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Sterling (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifford Rollins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Hazel Rollins
6 (c) If alive, give age 4-4 years

7. Birth date of deceased (mo., day, yr.) 6-3-87

8. AGE: Years	Months	Days	If less than one day
61	5	22	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Nathaniel Rollins
13. Birthplace ?

MOTHER
14. Maiden Name Sara Pomeroy
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov. 28 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Union cemetery
Location Leesburg, Va.

18 (a) Funeral director John D. Mitchell
(b) Address Baltimore, Md.

19 (a) NOV 25 1948 Curtis Williams M.D.
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1948, at 4.25 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-20 1948 to 11-25 1948, and that I last saw him alive on 11-25 1948

Immediate cause of death: Massive upper Gastro-intestinal hemorrhage — Duration

Due to Duodenal ulcer

Due to

Other Conditions Arteriosclerosis generalized
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Duodenal ulcer, arteriosclerosis, splenomegaly, cardiomegaly

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D.D. Jackson M.D.
Address The Johns Hopkins Hospital Date signed 11/26/48

VS 150

Meehan

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

68912 — 937 — Registered No. 68912

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Eaton & Walkers Ave.
(c) Hospital or institution: Jenkins Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs. 10
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 Valley St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Catherine Meehan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife John Meehan

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug 25, 1869

8. AGE: Years	Months	Days	If less than one day: hr.	min.
79	3	0		

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Deceased Thomas Ellis
13. Birthplace Ireland

MOTHER
14. Maiden Name Deceased Maria Everson
15. Birthplace Ireland

16 (a) Informant Mrs. Esther J. Meehan
(b) Address 1519 Easton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Edmund W. Coghlan
(b) Address 924 E. Eager St.

19 (a) NOV 25 1948 (Date rec'd by registrar) Clinton Williams M.D. (Registrar)
(b) —

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1948 at 3 00 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1939 to Nov. 25 1948, and that I last saw her alive on Nov. 25 1948.

Immediate cause of death: Congestive failure — Duration

Due to: Arteriosclerotic hypertensive CVD

Due to:

Other Conditions: Old cerebrovascular accident
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Herbert J. Lenchan M.D.
Address St. Agnes Hosp. Date signed 11/25/48

VS 150

668913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 668913

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 N Kenwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 N Kenwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Loretta M. Yost

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
Female	Wht	Married

6 (b) Name of husband or wife John W. B. Yost
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 14 1883

8. AGE: Years	Months	Days	If less than one day
65	8	11	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John F. O'Brien
13. Birthplace Ireland

MOTHER
14. Maiden Name Grace A. Hamilton
15. Birthplace Ireland

16 (a) Informant John W. B. Yost
(b) Address 6 N Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3600 E Baltimore St

19 (a) NOV 25 1948 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1948, at 12:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947, to Nov. 25 1948, and that I last saw her alive on Nov. 24 1948.

Immediate cause of death	Duration
Carcinoma of liver	
Due to metastasis from Carcinoma stomach	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1947 - 3 mos
Major findings of operation: Ca of stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?
(e) Means of injury

23. Signature Charles C. MacMillan M. D.
Address 29 E. Balt St Date signed Nov. 26

VS 150

(68914) (68914)

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93c

Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any false statement or misinformation should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2053 Gough Street
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2053 Gough St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Michael Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married

6 (b) Name of husband or wife Rose Semrad
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/22/85

8. AGE: Years	Months	Days	If less than one day
63	3	2	hr. min.

9. Birthplace Baltimore · Md. (Town, county, and state)
10. Usual Occupation Metal Worker
11. Industry or business

FATHER
12. Name Martin Miller
13. Birthplace Balto

MOTHER
14. Maiden Name Mary ?
15. Birthplace Balto

16 (a) Informant Rose Miller
(b) Address 2053 Gough St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly & Zeiler
(b) Address 403 N. Wolfe St.

19 [a] NOV 25 1948 (b) Huntington Williams, M.D. Registrar
Registered by Registrar

NOV 25 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24/ 1948, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1948, to Nov. 24 1948, and that I last saw h[illegible] alive on Nov. 24 1948.

Immediate cause of death: Pulmonary Edema
Due to: arteriosclerotic Heart Disease with myocardial insufficiency
Due to: Decompensated hypertensive heart disease
Due to: Obesity

Duration: 2 days. 7 days.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify yes or no)
(e) Means of injury

23. Signature Geo. N. Lefevre M. D.
Address 422 S. Bouton St. Date signed 11/26/48

G68915

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68915 Registered No. 3697

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 217 Stricker St.
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 Stricker St (If rural give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Henson
3 (b) If veteran, name war —
3 (c) Social Security Account No. unknown

4. Sex Male | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mrs Alverta Henson
6 (c) If alive, give age 52 years

7. Birth date of deceased mo. August day, yr. 1895

8. AGE: Years 53 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation plasterer
11. Industry or business —

FATHER
12. Name Charles W. Henson
13. Birthplace Balto md

MOTHER
14. Maiden Name Rose Dennis
15. Birthplace md

16 (a) Informant Mrs Alverta Henson
(b) Address 217 Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/48 (month) (day) (year)
(c) Cemetery or crematory mt auburn
Location md

18 (a) Funeral director George G. Kelson
(b) Address 1303 Presstman ST

19 NOV 25 1948 (Date rec'd by registrar) (b) Huntington Nabrawille, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 24 - 1948, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17 - 1948, to 11-24 - 1948, and that I last saw him alive on 11-23 - 1948

Immediate cause of death Pneumonia | Duration 1 week

Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank L. Turner M. D.
Address 2901 Eastern Ave. Date signed 11-25-48

VS 153

668916

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668916 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 725 Asquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS WILLIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1903

8. AGE: Years	Months	Days	If less than one day
45	5	14	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name -- --
13. Birthplace

MOTHER
14. Maiden Name ------
15. Birthplace

16 (a) Informant Clarence Barnes
(b) Address 301 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director THOMAS E. KELSON
(b) Address 1303 Pressman St.

19 (a) [illegible] 25 1948 (Date rec'd by Registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1948, at 4:32PM

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 11/25/48

G68917

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

G68917 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 South Augusta
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 S. Augusta ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adolphus Aden Anderson.
3 (b) If veteran, name war 1 | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: w | 6 (a) Single, married, widowed, or divorced: Married.
6 (b) Name of husband or wife: Lillian Anderson
6 (c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) Aug 29, 1897
8. AGE: Years 51 | Months 2 | Days 26 | If less than one day: hr. min.
9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation
11. Industry or business Tuttle Co.

FATHER 12. Name Aden S Anderson
13. Birthplace Maryland.

MOTHER 14. Maiden Name Maggie Bumbler
15. Birthplace Maryland.

16 (a) Informant Mrs Lillian Anderson
(b) Address 20 South Augusta
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/48 (month) (day) (year)
(c) Cemetery or crematory National Cemetery
Location Bard, City
18 (a) Funeral director Edgar S. Mayhew
(b) Address Catonsville, Md.
19 NOV 25 1948 (Date rec'd by registrar) (b) Funeral for Williams, Mgr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1948, at 8 00 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 19 . to Nov 24 1948.
and that I last saw him alive on Nov 24 1948.

Immediate cause of death Carcinomatosis
Due to Carcinoma of Colon
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alex H. Crowther M. D.
Address 4009 Harford Ave Date signed 11/26/48

V3.3

G68918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12a

Registered No. G68918

Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1130 W. FRANKlin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 W. FRANKlin (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Hubbard Fitchett

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-5944

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Bessie Fitchett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1872

8. AGE: Years	Months	Days	If less than one day: hr.	min.
76yrs.	2	-		

9. Birthplace EASTville, VA. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Colup Fitchett
13. Birthplace EASTville, VA.

MOTHER
14. Maiden Name Ann Fisher
15. Birthplace EASTville, VA.

16 (a) Informant FANNIE Fitchett Wallace
(b) Address 130 W. FRANKlin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22 48 (month) (day) (year)
(c) Cemetery or crematory Druhurst Mem Park
Location Baltimore Md

18 (a) Funeral director Isaiah L Thomas Sr
(b) Address 1648 Montgomery St

NOV 25 1948 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1948, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27-1948 to 11-23, 1948, and that I last saw him alive on 11-22-1948.

Immediate cause of death	Duration
CARDIAC Failure	week
Due to CARDIO-renal disease	7wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 W. Franklin St Date signed 11-24-48

VS 150

(68919

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 94a

Registered No. 68919

The items of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3919 Woodridge Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3919 Woodridge Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas G. Reinhart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Kate Margaret Woodey

6 (c) If alive, [illegible] years

7. Birth date of deceased (mo., day, yr.) July 1, 1881

8. AGE: Years 67 | Months 4 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Post office

FATHER
12. Name Henry Reinhart
13. Birthplace Md

MOTHER
14. Maiden Name Caroline —
15. Birthplace —

16 (a) Informant Earl E. Reinhart
(b) Address 3919 Woodridge Ave

17 (a) Burial (b) Date thereof Nov 27 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Pk
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Smith Jr
(b) Address 4101 Edmondson Ave

19 (a) [illegible] (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1948, at 10¾ M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1948 to 11-25 1948, and that I last saw him alive on 11-25 1948.

Immediate cause of death: Coronary occlusion — Duration

Due to Coronary artery disease

Due to

Other Conditions Pernicious anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. W. Ishaye M. D.
Address 3921 Edmondson Date signed 11-26-48

VS 150

H. W. Ishaye

G68920

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

927

G68920

Registered No. 7

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2522 E. Eager St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2522 E. Eager St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUST MESNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 9, 1870

8. AGE: Years	Months	Days	If less than one day
78	9	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William Mesner
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Muller
15 Birthplace

16 (a) Informant Mrs Margaret Foster
(b) Address 2522 E. Eager St,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (c) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) NOV 29 1948 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1948 19 , at 9:00 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 19 48 to 11/24 19 48 and that I last saw him alive on 11/23 19 48

Immediate cause of death: hypostatic pneumonia
Due to: myocardial insufficiency
Due to:
Other Conditions: arterio-sclerosis

(Include pregnancy within 3 months of death)

Duration: 3 days.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify Yes or No)
(e) Means of injury

23. Signature L. C. Tobias
Address 447 N. Kenwood Ave. Date signed 11/24/48

VS 150

G68921

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1948

Registered No. G68921

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2518 W. Fayette Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) FULL NAME Minnie L. Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Joseph Doyle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 13, 1885

8. AGE: Years	Months	Days	If less than one day
63	4	11	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Spencer
13. Birthplace Maryland

MOTHER
14. Maiden Name Dorn ?
15 Birthplace Maryland

16 (a) Informant Thomas S. Wright
(b) Address 2518 W. Fayette Street

17 (a) burial (Burial, cremation, or removal) **(b) Date thereof** 11/27/48 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) NOV 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6, 1948 to Nov 24, 1948, and that I last saw h[illegible] alive on Nov 23, 1948

Immediate cause of death Cerebral Hemorrhage — **Duration**

Due to Hypertensive Cardiovascular disease — 4 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify two of these)
(e) Means of injury

23. Signature Leonard Yaffee
Address 3101 W Baltimore St. Date signed 11/26/48

VS 139

668922 BALTIMORE CITY HEALTH DEPARTMENT 668922

CERTIFICATE OF DEATH

97 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Home for the Aged Blvd
(c) Hospital or institution: 1200 Valley St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1908 Cascadell Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mazie Driscoll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife Henry Driscoll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 4th 1881

8. AGE: Years	Months	Days	If less than one day
67	8	20	hr. min.

9. Birthplace Phila-Delphia Pa (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business at home

FATHER
12. Name Frederick Himber
13. Birthplace Penna.?

MOTHER
14. Maiden Name Maggie Irvine
15. Birthplace Penna.?

16 (a) Informant Sister Kinsman
(b) Address 1200 Valley

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (Month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director C. F. Lemmon
(b) Address 4611 Park Heights

19 (a) NOV 28 1948 (Date received by registrar) (b) Registrar for Baltimore

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1948, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1948, to Nov 24 1948, and that I last saw h er alive on Nov 23 1948

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Cerebral Arterio Sclerosis	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature E. Sullivan M. D.
Address 6312 Norfolk Ave Date signed 12/2/48

VS 150

68343 BALTIMORE CITY HEALTH DEPARTMENT 68343

CERTIFICATE OF DEATH 948

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Avenue
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Arbutus (If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 Linden Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Withers

3 (b) If veteran, name war

3 (c) Social Security Account No

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Matilda E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20, 1891

8. AGE: Years 57 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)

10. Usual Occupation motorman

11. Industry or business Balto. Transit Co.

FATHER 12. Name Wm. T. Withers

13. Birthplace Md.

MOTHER 14. Maiden Name Louise Schmal

15. Birthplace Md

16 (a) Informant Mrs. Matilda E. Withers

(b) Address 1730 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore

18 (a) Funeral director George A. Farley

(b) Address Fulton Ave & Fayette St.

NOV 29 1948 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Nov. 1948, at 7:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D. Medical Examiner.

Date signed 25 Nov. 1948

VS 151

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668924
JL. 124776

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1 ✓ 124a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Sep.

6 (b) Name of husband or wife Hazel Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1900

8. AGE: Years	Months	Days	If less than one day
48 yrs.	8	27	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business Balto. City Swimming Pool

FATHER
12. Name Robert Wilson
13. Birthplace Penna.

MOTHER
14. Maiden Name Jennie Laughn
15. Birthplace Penna.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)
(c) Cemetery ~~crematory~~ Rosedale
Location Martinsburg, W. Va.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place, Balto., Md.

19 (a) NOV 29 1948 Date received by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1948 at 10.30 Am

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 22 1948 to Nov. 23 1948, and that I last saw him alive on Nov. 23 1948

Immediate cause of death	Duration
Pulmonary edema.	
Due to acute left ventricular failure	
Due to severe anemia	
Other Conditions Carcinoma Sigmoid Rectal Bleeding (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)
(Specify type of place)
(e) Means of injury

23. Signature William H. Hunter M.D.
Address Balto City Hosp Date signed Nov 29 48

VS '50

731

668925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668925 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 Days

2. USUAL RESIDENCE OF DECEASED: Same
(a) State Md. (b) County Talbot
(c) City or town Cambridge (If outside city or town limits, write RURAL and give town)
(d) Street No. Oakley St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Dr. HENRY TAWES, M.D.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Winnie Leach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) December 4, 1879

8. AGE: Years 68 | Months 11 | Days 21 | If less than one day: hr min

9. Birthplace Crisfield, Maryland (Town, county, and state)
10. Usual Occupation physician
11. Industry or business

FATHER
12. Name Leonard Smith Tawes
13. Birthplace Accomac County, Va.

MOTHER
14. Maiden Name Mary Lawson
15. Birthplace Accomac, County, Va.

16 (a) Informant Granville LeCompte
(b) Address Cambridge, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/48 (month) (day) (year)
(c) Cemetery Old Trinity
Location Church Creek, Maryland

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place, Baltimore, Md.

19 (a) (Date received by Registrar) NOV 29 1948 (b) Hunting for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1948 at 11:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-16-48 to 11-25 1948 and that I last saw him alive on 11/25/48

Immediate cause of death: Cardiac failure — Duration

Due to: uraemia, nephrosclerosis

Due to: arteriosclerotic heart disease

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause for which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John LeCompte M. D.
Address Univ. Hosp. Date signed 4-26-48

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Only capitals used.

668926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125a

668926
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 St. James St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH BRYANT CAMPHARS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1916

8. AGE: Years 32 | Months 4 | Days | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: Stanen Camphars
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Luline ?
15. Birthplace: Unknown

16 (a) Informant: Mable Alexander
(b) Address: 1216 St. James Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvery
Location: Brooklyn Md.

18 (a) Funeral director: Elroy O. Wilson
(b) Address: 1006 Brantley Ave

19 NOV 27 1948 (b) Huntington Williams, M.D.
(Registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1948 at 9:55 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cystitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributory ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature John P. Davis M.D.
Medical Examiner
Date signed November 23, 1948

VS 151

G68927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G68927

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3735 Park Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3735 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DR. SAMUEL WEINBERG.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife Frances Weinberg.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1880.

8. AGE: Years	Months	Days	If less than one day
68		1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Physician.
11. Industry or business

FATHER
12. Name Nathan Weinberg,
13. Birthplace Germany.

MOTHER
14. Maiden Name Hester Kaufman,
15. Birthplace Germany.

16 (a) Informant Mrs. Frances Weinberg,
(b) Address 3735 Park Heights Ave.

17 (a) Burial (b) Date thereof 11/28/48.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Baltimore, Md.

18 (a) Funeral director [illegible]
(b) Address 1902 Eutaw Place.

19 (a) NOV 29 1948 (b) [illegible] Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26th. 1948 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1948 to Nov 26, 1948.
and that I last saw h[illegible] alive on Nov. 25 1948

Immediate cause of death	Duration
Coronary artery disease	1 mo
Due to Arteriosclerosis	
Due to	
Other Conditions Chr. Bronchitis, Bronchiectasis	5 yrs +

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. S. Shiling M. D.
Address 2426 Eutaw Place Date signed

M. S. SHILING

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68928

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 153

G68928
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Aves.
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 Whittier Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE ANN MONNESS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Arthur Monness
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1906

8. AGE: Years	Months	Days	If less than one day
42	7	11 12	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Julius Farbman
13. Birthplace Russia

MOTHER
14. Maiden Name Frances Tramer
15. Birthplace Philadelphia, Pa.

16 (a) Informant Julius Farbman
(b) Address 2208 Whittier Avenue

17 (a) Burial (b) Date thereof Nov. 28/ 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location 3600 E. Baltimore Street
18 (a) Funeral director Sol. Levinson & Bros.
(b) Address 1124-26 W. North Avenue

(a) Date received by registrar NOV 29 1948 (b) Registrar Huntington Williams, M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26/48 19 at 9.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31/48 19 to 11/26/48 19 and that I last saw h alive on 11/26/48 19

Immediate cause of death	Duration
Due to Lupus erythematosus disseminatus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. M. Kestner M. D.
Address 3006 N. Dillon Date signed 11/29/48

Correct and as completely important. Physicians: please write the causes of death clearly and legibly.

668929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56E

668929
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood Sts
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 143 S. Mulberry St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM RICKARD

3 (b) If veteran, name war: W.W. II

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1923

8. AGE: Years 25 | Months | Days | If less than one day: hr. min.

9. Birthplace Hagerstown Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Max Rickard
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Lillian Walsh
15. Birthplace Ireland

16 (a) Informant Max Rickard
(b) Address Hagerstown, Md

17 (a) Burial (b) Date thereof 11 30 48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rest Haven
Location Hagerstown Md

18 (a) Funeral director C. M. Snyder & Son
(b) Address Hagerstown

19 (a) Nov 29 1948 (b) Registrar Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1948, at 10:45 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 1 1948 to Nov. 26 1948, and that I last saw him alive on Nov 26 1948

Immediate cause of death: Granulomatous lymphoid extradural spinal tumor

Duration:

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Auld, M.D.

Address Univ. Hosp. Date signed 11/29/48

NOV 29 1948

X

68930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. 68930

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Avenue
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5001 Gwynn Oak Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy M. Horney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James N. Horney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 8/28/1913

8. AGE: Years	Months	Days	If less than one day
35	2	28 29	hr. min.

9. Birthplace Balto. Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Garnet Wickham
13. Birthplace Md.

MOTHER
14. Maiden Name Ella Hayden
15. Birthplace Md.

16 (a) Informant Mr. James N. Horney
(b) Address 5001 Gwynn Oak Ave.

17 (a) Woodlawn (Burial, cremation, or removal) (b) Date thereof 11/29/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address North & Pa. Aves.

NOV 27 1948
(Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26/48 1948, at 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13/ 1948 to 11/26/ 1948, and that I last saw her alive on 11/26/ 1948.

Immediate cause of death	Duration
CARCIN-!	
RESPIRATORY FAILURE	
Due to MULTIPLE MYELOMA	
Due to CLOUDY SWELLING KIDNEYS	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: PS ACCEPTED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 11/29/48

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

Mb4 668931 BALTIMORE CITY HEALTH DEPARTMENT 668931

CERTIFICATE OF DEATH 74a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Amarillo (If outside city or town limits, write RURAL and give town)
(d) Street No. 2609 Hayden Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francis M. Popham

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude T. Popham
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr): 12-14-75

8. AGE: Years 72 | Months 11 | Days 12 | If less than one day: hr. min.

9. Birthplace: Kansas (Town, county, and state)
10. Usual Occupation: Rancher
11. Industry or business: Self

FATHER
12. Name: Elias Popham
13. Birthplace: Indiana

MOTHER
14. Maiden Name: Elizabeth Finsey
15. Birthplace: Indiana

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/27/48 (month) (day) (year)
(c) Cemetery or crematory
Location Amarillo, Texas

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 27 1948 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26- 1948, at 4.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1948 to 11-26 1948.
and that I last saw h m alive on 11-26 1948.

Immediate cause of death: Leukemia, myeloblastic, subleukemic, acute — Duration: 4 months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Bull M. D.
Address Johns Hopkins Hosp Date signed Nov 26, 48

VS 150

G 3932

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 82a

G68932
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3020 Reisterstown Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR O. BABENDREIER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widower
6 (b) Name of husband or wife: Ada Babendreier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 21, 1870

8. AGE: Years 78 | Months 10 | Days 5 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Albert Babendreier
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia
15. Birthplace Germany

16 (a) Informant Mrs. Juliana S. Trautmann
(b) Address 3020 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26, 1948 at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1948 to Nov 26 1948 and that I last saw him alive on Nov 25 1948.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 mos.
Due to: General Arteriosclerosis — Duration: 5 years
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen F. Pullman M. D.
Address 6 E Biddle St Date signed 11-27-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68933 (1) G68933 Registered No. 1313

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 McDonogh Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: CHARLES E. WELLS

3 (b) If veteran, name war: —

3 (c) Social Security Account No. 213-10-4980

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Mary Wells

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27 1898

8. AGE: Years 50 yrs. Months 2 Days 25 If less than one day hr. min

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: ?

11. Industry or business

FATHER
12. Name: Edward Wells
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Rachel ?
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Burdella Cunningham
(b) Address: 2618 Hollins Ferry Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 27 48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Md.

18 (a) Funeral director: Walter B. Spriggs
(b) Address: 139 W. Hamburg St.

19 (a) 1948 (Registered by registrar) Washington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1948 at 3:12 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edgar T. Ward M.D. Medical Examiner.

Date signed 11-22-48

Physicians: please write the causes of death clearly and legibly. Cause of death as a consequence is frequently important.

6689.54

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6689.54

Registered No. 1212

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3801 Frederick Ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) Ly
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3801 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver E. Mitchell

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-09-4752

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nannie E.
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 12-20-1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	10	4		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Louden Park Cem. Co.

FATHER
12. Name Luther A. Mitchell
13. Birthplace Maryland

MOTHER
14. Maiden Name Maria Hanicke
15. Birthplace Maryland

16 (a) Informant Nannie E. Mitchell "wife"
(b) Address 3801 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 27 Nov. 48 (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location Baltimore - Md.

18 (a) Funeral director W. B. Hilbert & Son
(b) Address 1900 Eutaw Place

19 (a) NOV 27 1948 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 - 1948 at 11:10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 21 1948 to Nov 24 1948 and that I last saw h. in alive on Nov 24 1948.

Immediate cause of death Hypertensive Arterio Sclerotic Renal Disease with Uremia

Duration 16 mo

Due to Terminal Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 3833 W North Ave Date signed Nov 27 1948 M. D.

668935

ES-124615

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 668935

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution:
BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 51 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7200 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victor Leone (VITO LEONE)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Elizabeth LEES
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1894

8. AGE: Years	Months	Days	If less than one day
54	-	23	hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation BARBER
11. Industry or business SELF

FATHER
12. Name Vincent Leone
13. Birthplace Italy

MOTHER
14. Maiden Name Angelina Delmonte
15. Birthplace New York

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/48 (month) (day) (year)
(c) Cemetery or crematory Parklawn Cem.
Location Eastern Ave.

18 (a) Funeral director J. J. Fahey & Son
(b) Address 218 Light St. Huntington Williams, M.D.

19 (a) NOV 27 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-25 1948 at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 1948 to 11-25 1948 and that I last saw him alive on 11-25 1948

Immediate cause of death: Hemorrhage from ecrotum
Due to: Abdominal aortic aneurysm rupturing
Due to: syphilis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Osborne

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Vastine M. D.
Address Balto City Hosp. Date signed 26 Nov 48

VS 150

Street address is necessary. Physicians: please write the causes of death clearly and legibly.

G689.36

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G689.36 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Streets
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5203 Roland Ave Balto 10
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Mrs. Mennie Lawson

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	212-01-8801	Male	White	Married

6 (b) Name of husband or wife Mrs. Margaret Lawson
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Aug 27, 1895

8. AGE: Years	Months	Days	If less than one day: hr.	min.
53	3	0		

9. Birthplace Banks Garden, Virginia
(Town, county, and state)
10. Usual Occupation Real Estate
11. Industry of business

FATHER
12. Name Robert Lawson
13. Birthplace Virginia

MOTHER
14. Maiden Name Ghoen Waters
15. Birthplace Virginia

16 (a) Informant Mrs. Margaret Gullette Lawson
(b) Address 5203 Roland ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/29/48 (month) (day) (year)
(c) Cemetery or crematory Wytheville
Location Wytheville, Virginia

18 (c) Funeral director Francis Sisson
(b) Address Huntington West Virginia

19 (a) NOV 28 1948 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1948, at 4 35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1948, to Nov. 27 1948, and that I last saw him alive on Nov. 26 1948

Immediate cause of death: Myocardial Failure — Duration

Due to Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically

23. Signature H. C. Graybeal M.D.
M. D.
Address Union memorial Hospital Date signed 11-27-48

VS 150

6689.37 ES-120371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

✓ 6689.37 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1566 Ridgley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Ruhland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Div.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 1, 1876

8. AGE: Years	Months	Days	If less than one day
72	5	18	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jacob Ruhland
13. Birthplace Germany

MOTHER 14. Maiden Name Mary Wagoner
15. Birthplace Del.

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 / 27 / 48 (month) (day) (year)
(c) Cemetery or crematory Cook Hill
Location Rockville Pike

18 (a) Funeral director John F. Denny, Inc
(b) Address 715 Light St -30

19 (a) NOV 28 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 19 48 at 10:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-11 19 48 to 11-19 19 48 and that I last saw him alive on 11-19 19 48

Immediate cause of death Carcinoma of lung & metastases — Duration 1 year?

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation 6-16-48 8-22-48

Major findings of operation: Biopsies of metastatic carcinoma of lung

of autopsy: not obtained

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature David H. Marine M. D.
Address Balto City Hosp Date signed 11-27-48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 130

668938

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668938 Registered No. 124a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Parkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelm, Mr. Wm W.

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Grace V
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27 1867

8. AGE: Years 61 | Months 9 | Days — | If less than one day: hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Farm

FATHER
12. Name Jacob B Wilhelm
13. Birthplace Md

MOTHER
14. Maiden Name Angelina Haly
15. Birthplace Md

16 (a) Informant Mrs Wm W Wilhelm
(b) Address Parkton Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov 30/48 (month) (day) (year)
(c) Cemetery or crematory Forestview
Location Baltimore Md

18 (a) Funeral director Edw C Tipton
(b) Address Hampstead Md

19 (a) NOV 28 1948 Registered by Registrar (b) Huntington Williams, M.D. Registrar

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1948, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1948, to 11-27 1948, and that I last saw him alive on 11-27 1948.

Immediate cause of death
Respiratory Failure
Cardiac Failure
Duration

Due to
Poss coronary thrombosis

Due to

Other Conditions Renal calculus dept ?
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Rosenberg M.D.
Address Univ. Hosp Date signed 11-27-48

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information must be correctly supplied.

G689.39

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G689.39
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 W. Lombard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 903 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES L. BEATTY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Julia L
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1881

8. AGE: Years	Months	Days	If less than one day
67 yrs.	2	17	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business McDowell Candy Company

FATHER
12. Name James Beatty
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Julia L. Beatty
(b) Address Linthicum Post Office, Md.

17 (a) Burial (b) Date thereof 11/29/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson & Longwood Sts

18 (a) Funeral director John J. Cowan & Son
(b) Address 901 & 3 Hollins Street

19 (a) NOV 28 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1948 2:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
A.S.C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner M.D.
Date signed 11/24/48

VS 181

Please write the causes of death clearly and legibly.

G68940

GM. 124793

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

91a

G68940
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 657½ W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Bleuel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) April 13, 1902

8. AGE: Years	Months	Days	If less than one day
46	7	13	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Helper

11. Industry or business Koesters Bakery

FATHER
12. Name Charles Bleuel
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Caplin
15. Birthplace Germany

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (b) Date thereof 11/30/48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Kenyon Ave + Belair Rd

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.
Huntington Williams, M.D.

19 (a) NOV 29 1948
(Date rec'd by registrar) Registrar

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 1948 at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23 1948 to 11-26 1948
and that I last saw him alive on 11-26 1948

Immediate cause of death	Duration
Cardiac failure	
Due to subacute bacterial endocarditis	
Due to congenital aortic valvular anomaly	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Yes Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Vieten, Jr. M. D.
Address Balto City Hosp Date signed Nov 28

G68941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68941

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2834 N. Calvert Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2834 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) NO
If yes, name country

3 (a) FULL NAME Miss Nannie Belle Brown (Miss Nannie Belle Brown)

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. NONE

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: XXXXXXXXXXX

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) abt. 7/27/1873

8. AGE: Years: about-75 | Months: 3 4 | Days: 29 0 | If less than one day: hr. min

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Retired - Baltimore City

11. Industry or business: Public School Teacher

FATHER
12. Name: John Wesley Brown
13. Birthplace: Waverly, King George Co., Va.

MOTHER
14. Maiden Name: Nannie Stone Turner
15. Birthplace: Yalton, Charles Co., Maryland

16 (a) Informant: Miss Daisy D. Ashton (Niece)
(b) Address: Potomac Beach, Westmoreland Co. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29. 1948 (month) (day) (year)
(c) Cemetery or crematory: St. Pauls Church Cemetery
Location: King George County, Virginia

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 W. North Av., Balto. 1. Md.

19 (a) (Signature of registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Nov. 1948, at 10:37 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Thrombosis

Due to: Hypertensive Cardio-Vascular Disease.

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Wm. H. Kammerer, M.D. Medical Examiner.
Date signed 27 Nov. 48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G68942 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4814 Frederick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4814 Frederick Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Herman Charles Schindle

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-09-8087

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1885

8. AGE: Years 63 | Months — | Days 3 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Crown Cork & Seal Co.

FATHER
12. Name Herman Schindle
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine A. Lyasey
15. Birthplace Germany

16 (a) Informant John Holdy
(b) Address 2307 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schmidt
(b) Address 2401 Frederick Ave.

19 (a) 28 1948 (Date received by registrar) Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1948, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948, to Nov 25 1948, and that I last saw him alive on Nov 25 1948.

Immediate cause of death: Death Coronary Thrombosis — Duration: 1 minute
Due to: Coronary Sclerosis — years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. J. Mendelis, M.D.
Address 6511 N. Bentalou Date signed 11/29/48

668943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

668943 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2461 Westport St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2461 Westport St (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME MINNIE B. FREEMAN

3 (b) If veteran, name war | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Wm. H. Freeman
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) July 29, 1875

8. AGE: Years	Months	Days	If less than one day
73	3	28	hr. min.

9. Birthplace Anne Arundel Co. Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name John Marshall
13. Birthplace Wash. D. C.

MOTHER
14. Maiden Name Eliza Baldwin
15. Birthplace A. A. Co. Md

16 (a) Informant William N. Freeman
(b) Address 2461 Westport St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29 1948 (month) (day) (year)
(c) Cemetery or crematory Cedar Lawn Cem
Location Annapolis Md

18 (a) Funeral director Wm. Md. John W. Tuttle & Son
(b) Address 5311 Edmondson Ave

19 (a) NOV 28 1948 (b) [illegible]
Date rec'd by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1948, at 10:41 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 19 48 to Nov 26 19 48 and that I last saw h[illegible] alive on Nov 25 19 48.

Immediate cause of death Carcinoma of Breast — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Paul Thompson M.D.
Address 301 Arnold Date signed 11-28-48

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G68944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G68944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2020 W. FAYETTE ST

(c) Hospital or institution: NONE

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) 59 YRS 7 MOS

2. USUAL RESIDENCE OF DECEASED:

(a) State MARYLAND (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 2020 W FAYETTE ST (If rural give location)

(e) Citizen of foreign country? If yes, name country — Yes or No: ✓

3 (a) FULL NAME CATHERINE ELIZABETH SUMMERS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife GEORGE THOMAS

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) APRIL 25 1889

8. AGE: Years	Months	Days	If less than one day
59	7	2	— hr. — min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business OWN HOME

FATHER

12. Name HENRY BLUM

13. Birthplace GERMANY

MOTHER

14. Maiden Name THELMA — ?

15. Birthplace GERMANY

16 (a) Informant MRS. DORIS STEVENS

(b) Address 631 N. ROBINSON ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30, 1948 (month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore City

18 (a) Funeral director MRS. JOHN M. TELFER & SON

(b) Address 5311 Edmondson Ave.

19 (a) NOV 28 1948 (Date rec'd by registrar) (b) Huntington Williamson, M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 27 1948 at 12.10A M

21. I certify that death occurred on the date above stated; that I attended deceased from AUGUST 1948 to NOVEMBER 27 1948, and that I last saw HER alive on NOVEMBER 26 1948

Immediate cause of death BRONCHO PNEUMONIA — Duration 24 HRS.

Due to CARDIAC FAILURE — 3 DAYS

Due to CHRONIC MYOCARDITIS & MYOCARDIAL DEGENERATION — ?

Other Conditions SECONDARY ANEMIA

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Melvin N. Borden M. D.

Address 2030 W. Fayette St Date signed 11/27/48

VS 150

G68945

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G68945 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 W North Ave.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 W North Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Duffy

3 (b) If veteran, name war No | 3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Eleanor F. D. Duffy
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr) Nov-23-1852

8. AGE: Years 86 | Months 0 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation retired
11. Industry or business Law

FATHER 12. Name Edward Duffy
13. Birthplace Balto Md.

MOTHER 14. Maiden Name Emma C. McMillan
15 Birthplace Balto Md.

16 (a) Informant Mrs. Henry Duffy - (wife)
(b) Address 110 W North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Elliott City

18 (a) Funeral director Sullivan Morgan Co.
(b) Address 108 W North Ave.

19 (a) (Date received by Registrar) NOV 28 1948 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1948, at 8.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1948 to November 1948. and that I last saw h[illegible] alive on Nov. 25 1948.

Immediate cause of death: Hemiplegia — Duration
Due to arteriosclerosis.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W Lincoln Ford
Address 20 E. Preston St. Date signed 11/27/48

VS 150

668946

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

668946 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Boarman Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Galek

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Elaine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
41			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Auto mechanic
11. Industry or business

FATHER
12. Name John Galek
13. Birthplace Poland

MOTHER
14. Maiden Name Agnes Janicko
15. Birthplace Poland

16 (a) Informant Elaine Galek
(b) Address 2907 Boarman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 29 48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

19 (a) NOV 28 1948 (Date received by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1948, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Compound Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-27-48 at 1:30 A.M.
(b) Where did injury occur? Broadway & Hoffman St.
(c) Did injury occur at home, on farm, in industrial place, in public place? Public place While at work? No
(d) Means of injury: Auto struck bridge support

23. Signature [illegible] M.D.
Medical Examiner
Date signed 12-2-48

Huntington Hillcrest, Md.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CORRECTED 1-11-49

G689:7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 1 B

G689:7

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 706 Mortonia Rd

(c) Hospital or institution: The Mount

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State N. Y. (b) County

(c) City or town New York (If outside city or town limits, write RURAL, and give town)

(d) Street No. Lambs Club (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Clyde Veaux

3 (b) If veteran, name war

3 (c) Social Security Account No. Seperate

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 64 Months: Days: If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Actor

11. Industry or business

FATHER

12. Name: David

13. Birthplace: Russia

MOTHER

14. Maiden Name: Rosa

15. Birthplace: Russia

16 (a) Informant: Irving Silverman

(b) Address: 2710 Oswego Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-29-48 (month) (day) (year)

(c) Cemetery or crematory: Adas Israel

Location: Washington, D.C.

18 (a) Funeral director: Jacob Lewis Inc

(b) Address: 2400 Eutaw Place

19 (a) NOV 28 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1948, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to Nov 1948, and that I last saw him alive on Nov 25 1948.

	Duration
Immediate cause of death: Carcinomatosis	8 mo
Due to Carcinoma of Sigmoid	10 mo
Due to Carcinoma of Prostate	3 yr.

Other Conditions

(Include pregnancy within 3 mos. of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence a: M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Lester A. Kolman M.D.

Address 3700 Dorchester Date signed Nov 27 1948 M D

VS 150

Lester A. Kolman

G68948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G68948
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Fruma Meyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 74 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business

FATHER
12. Name: Haskel
13. Birthplace: Russia

MOTHER
14. Maiden Name: Emma
15. Birthplace: Russia

16 (a) Informant: Mrs Mary Hoffman
(b) Address: 2901 Thorndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-48 (month) (day) (year)
(c) Cemetery or crematory
Location: Hebrew Herring Run

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2400 Eutaw Place

19 (a) NOV 28 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1948 at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 1948 to Nov 26 1948. and that I last saw her alive on Nov 26 1948.

Immediate cause of death: Chronic cardio vascular disease — Duration
Due to
Due to
Other Conditions: General Arterio-sclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Jerome J. Blumberg M. D.
Address: Levindale Home Date signed 11/26/48

Contagious Diseases, WITH UNFAILING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Huntington Williams, M.D.

G68949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G68949 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address /
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 36yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3457 Cottage Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 77 | Months | Days | If less than one day: hr. min.

9. Birthplace Lath (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph

13. Birthplace Lath

MOTHER 14. Maiden Name Not Known

15. Birthplace Latty

16 (a) Informant Joseph Smith

(b) Address 3457 Cottage Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-48 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Holy Rd & Hamilton Ave

18 (a) Funeral director Leek Rennyson

(b) Address 2100 Eutaw Place

NOV 28 Baltimore (b) Maryland

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26/48 19 at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20/48 19 to 11/26/48 19 and that I last saw her alive on 11/25 19

Immediate cause of death Myocardial infarction — Duration

Due to arterio-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. P. Young M. D.

Address U. B. Hospital Date signed 11-27

VS 100

668950

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

668950 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Broadway # 31 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL SILVERSTEIN
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife AOA
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years 68 | Months | Days | If less than one day: hr. min.
9. Birthplace Romania (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name not known
13. Birthplace Romania

MOTHER
14. Maiden Name not known
15. Birthplace Romania

16 (a) Informant Ada Silverstein
(b) Address 22 So Broadway
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location
18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place
19 (a) Date received by registrar (b) Registrar's signature Huntington Williams M.D. registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 November 1948 at 12:30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 21 1948 to Nov 27 1948 and that I last saw h[illegible] alive on November 26 1948

Immediate cause of death: Cerebrovascular Hemorrhage — Duration
Due to
Due to
Other Conditions: Benign Prostatic Hypertrophy, Arteriosclerotic Coronary Artery Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ellwood Robert Golden M.D.
Address SINAI Hospital Date signed 11/27/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 193

83a

668951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

668951 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 N. Charles St.
(c) Hospital or institution:
Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3133 Oakford Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME DISTILLER, Morris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Distiller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
63				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired merchant
11. Industry or business

FATHER
12. Name Melowin
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Mary Distiller
(b) Address 3100 Oakford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Levy Inc
(b) Address 2400 Eutaw Place

19 NOV 28 1948 Filed for record by registrar Keating for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1948, at 5.55 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 1946 to Nov 27 1948
and that I last saw h alive on Nov 27 1948

Immediate cause of death Hypertensive Cardiovascular Disease — Duration 2 yrs

Due to Cardiac Enlargement — 2 years

Due to Acute Failure — 2 days

Other Conditions Pulmonary Edema — 2 days

(Including pregnancy, abortion, childbirth)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature A A Wendroff M.D.
Address 4603 Park Ave Date signed 11-29-48

VS 150

658952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. 66892

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S.C. (b) County
(c) City or town ORANGEBURG, (If outside city or town limits, write RURAL and give town)
(d) Street No. 361, Park, Ave. N.E. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas . R. Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 10-28-48

8. AGE: Years	Months	Days	If less than one day
	1	28d	hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Henry Moore
13. Birthplace S.C.

MOTHER
14. Maiden Name Melba Redman
15. Birthplace S.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/28/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Orangeburg S.C.

18 (a) Funeral director Ulmer Funeral Home
(b) Address 2008 Orleans St

19 (a) NOV 28 1948 (Date rec'd by registrar) (b) Lemington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. - 28 1948 at 2 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27-1948 to 11-28-1948 and that I last saw him alive on 11-28-1948

Immediate cause of death: Heart failure — Duration

Due to Congenital malformation of heart

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Congenital heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harriet G. Fried M.D.
Address Johns Hopkins Hospital Date signed 11/28/48

X

6689:53

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

166

Registered No. 6689:53

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 N. Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOU EMMA CLYBURN

3 (b) If veteran, name war ———

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Wyatt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9,

8. AGE: Years	Months	Days	If less than one day
33	6	..	hr. min.

9. Birthplace Lancaster, S. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James McKenney
13. Birthplace Lancaster, S. C.

MOTHER
14. Maiden Name Maggie Foster
15. Birthplace Lancaster, S. C.

16 (a) Informant Mary E. Nicholson
(b) Address 405 N. Carrollton Avenue

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 11/28/48 (month) (day) (year)
(c) Cemetery or crematory Lancaster S. C.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3229 W. Lafayette Ave

19 NOV 29 1948 (Date rec'd by registrar) (b) Kunkin for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1948 at 11:32 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet-wound of chest.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or secondary ☐ cause of death, fill in the following:
(a) Date of injury 11-25-48 at Approx. 11 P. M.
(b) Where did injury occur? 670 W. Saratoga Street
(c) Did injury occur at home, on farm, industrial place, in public place? House While at work? No
(d) Means of injury Firearms

23. Signature E. L. Royer M.D. for A. A. Marshall M.D. Medical Examiner.
Date signed 11/27/48

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
   a. Baltimore City, Maryland
   b. Street address
   c. Hospital or institution

   d. Length of stay in hospital or inst. yrs., mos., or days
   e. Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED
   a. State
   b. City or town
   c. Street No.
   d. Citizen of foreign country
   If yes, name country

3. a. FULL NAME

   b. If veteran, name war
   c. Social Security Account No.

4. Sex
5. Color or race
6. a. Single, married, widowed, or divorced

   b. Name of husband or wife
   c. If alive, give age years

7. Birth date of deceased, mo., day, yr.
8. AGE: Years Months Days If less than one day hr. min.
9. Birthplace (City, county and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16. Informant
    Address
17. Date of death
    Burial, cremation or removal
    Cemetery or crematory
    Location
18. Funeral director
    Address
19. [illegible] Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH at M

21. I certify that death occurred on the date stated, that I attended deceased from to and that I last saw h alive on

Immediate cause of death — Duration

Due to,

Due to

Other Conditions

Date of operation

Major findings of operation:

of autopsy

If death was due to external cause (violence), fill in the following:
(Accident, suicide or homicide)

a. Date of occurrence at M
   Where did injury occur?

PHYSICIAN

Signature

Address

Please write plainly. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
a Baltimore City, Maryland
b Street address
c Hospital or institution

d Length of stay in hospital or inst. yrs., mos., or days
e Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED
a State b County
c City or town
d Street No.
e Citizen of foreign country? Yes or No
If yes, name country

3 a FULL NAME
[redacted] If veteran, name war
b Social Security Account No.

4. Sex
5. Color or race
6 a Single, married, widowed or divorced
b If married, widowed or divorced
6 b Name of husband or wife
6 c If alive, give age years
7. Birth date of deceased mo. day yr.
8. AGE: Years Months Days If less than one day
9. Birthplace
Town, county and state
10. Usual Occupation
11. Industry or business
12. Name
13. Birthplace
14. Maiden name
15. Residence
16 a Informant:
b Address
17 a Burial
Cemetery or crematory
b Location
18. Funeral director
Address
19. Attending physician

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 at M
21. I certify that death occurred on the date above stated, that I attended deceased from 19 to 19
and that I last saw h alive, on 19
Immediate cause of death
Duration
Due to
Due to
Other Conditions
PHYSICIAN
Date of operation
Major findings of operation:
of autopsy
22. If death was due to external causes, fill in the following:
a Accident, suicide or homicide?
b Date of occurrence M
c Where did injury occur?
d How did injury occur?
e Means of injury
f Signature
Address

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

J L*- 12447-58

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(c) Street No. 1129 Hanlesche St.
(d) Citizen of foreign country? If yes, name country

3. (a) FULL NAME Edith Marsh
(b) If veteran, name war
(c) Social Security Account No.

4. Sex F
5. Color or race W
6. (a) Single, married, widowed, or divorced Widow
(b) Name of husband or wife
(c) If divorced, give date years

7. Birth date of deceased (mo., day, yr.) June 20, 1873
8. AGE: Years 75 Months 4 Days 7 If less than one day hrs. min.

9. Birthplace Mich.
10. Usual Occupation
11. Industry or business

FATHER
12. Name Daniel Kyser
13. Birthplace Mich.

MOTHER
14. Maiden Name Mindy ?
15. Birthplace Mich

16. (a) Informant B. C. H. Records
(b) Address 1940 Eastern Ave.

17. (a) Burial (Burial, cremation, or removal)
(b) Date thereof 11 30/43 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem
Location Jump dis
18. (a) Funeral director Wm Cook Jno
(b) Address 127 Paul
19. (a) (Date received by registrar) Entering to Edmondson

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1943 PM 3.17 M

21. I certify that death occurred on the date stated above, at the hour stated above, and that I last saw her alive on Nov. 27 1943

Immediate cause of death: Carcinomatosis — Duration: ?

Due to: Adeno carcinoma Sigmoid

Due to:

Other Conditions: Malnutrition, dehydration.

Date of operation 7/29/43
Major findings of operation: as above

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(d) Did injury occur about home, on farm, in industrial place, or in public place? Where
(e) Means of injury
23. Signature E Edmondson
Address Baltimore City Hosp Date signed 11/30/43

PHYSICIAN

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
a. Baltimore City, Maryland
b. Street address 1100 N. Caroline St.
c. Hospital or Institution St. Joseph's
d. Length of stay in hospital or inst. yrs., mos., or days 2 da.
e. Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED
a. State Md.
b. County
c. City or town Baltimore
d. Street No. 1611 St. Paul
e. Citizen of foreign country
If yes, name country

3. (a) FULL NAME Joseph Henry Lee
(b) If veteran, name war No
(c) Social Security Account No. None

4. Sex M.
5. Color or race W.
6. (a) Single, married, widowed, or divorced S.
(b) Name of husband or wife
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1868
8. AGE Years Months Days If less than one day, hours or minutes
Approx. 60
9. Birthplace (State, county, and city) Baltimore
10. Usual Occupation None
11. Industry or business

PARENTS

12. Name Michael Lee.
13. Birthplace Ireland
14. Maiden Name Mary E. Cross
15. Birthplace England

16. Interment, Cremation, or Removal Clarke Lee
Address 1611 St. Paul St.
Burial Date of burial 11-30-43
17. Cemetery or crematory New Cathedral Cem.
Location Edmondson Ave
18. Funeral director Wm. Cook
Address

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1943 at 1:00 P.M.
21. I certify that death occurred on the date stated above at the hour stated above, and that I last saw deceased on Nov. 26, 1943, and that I last saw him alive on Nov. 28, 1943
Immediate cause of death Generalized arteriosclerosis
with Cerebral arteriosclerosis
Due to Osteoarthritis
Due to Decubitus ulcer
Due to Malnutrition
Other Conditions

Duration

PHYSICIAN

Date of operation
Major findings of operation
of autopsy
22. In death was due to external causes (violence)
(a) Date of occurrence
Where did injury occur
(b) Did injury occur in or about the course of employment
Manner
Signature
Address

Please write the causes of death clearly and legibly. Physicians: Special Importance

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
   a. Baltimore City, Maryland
   b. Street address 1-18 Light St.
   c. Hospital or institution: So. Baltimore Gen. Hosp.
   d. Length of stay in hospital or inst., yrs., mos., or days 1 mo 2 days
   e. Length of stay in Baltimore, yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED
   a. State Md
   b. City or town Baltimore
   c. Street No. 213 S. Mills St.
   d. Citizen of foreign country? If yes, name country

3. FULL NAME William C. Sibley

5. If veteran, state war: No

Social Security No. 214-01-1277

4. Sex M
5. Color or race W
6. Single, married, widowed, or divorced S.
7. Date of death (month, day, year) July 20 1941
8. AGE Years 57 Months 3 Days 5
9. Birthplace Baltimore
10. Usual Occupation Laborer
11. Industry or business Not Given
12. Name of father Wm. J. Sibley
13. Birthplace Md.
14. Maiden Name of mother Addie Richardson
15. Birthplace Md.
16. Informant Mrs. Charles Sibley
    Address 354 Mt. Olivet Lane.
17. Burial, cremation, or removal Burial Date thereof 11-30-41
    Cemetery or crematory Woodlawn
    Location Woodlawn Station
18. Funeral director Wm. Cook Jr.
    Address 217 S. Eutaw St.
19. Date received for record Registrar

20. DATE OF DEATH (month, day, year) July 20 1941
21. I attended deceased from July 1 1941 to July 20 1941
    Last saw deceased alive July 19 1941
    Death occurred at 4:45 P.M.
    Cause of death: Coronary Thrombosis
    Duration: Hrs. 1 Days 1
    Contributory (Secondary)
    Duration: Yrs. Mos. Days
    Operation: Yes No
    Date of operation
    Major findings of operation
    Was autopsy performed? Yes
    Were findings considered in determining cause of death? Yes
    If death was due to external causes (violence) fill in the following:
    Accident, suicide or homicide?
    (a) Date of occurrence at M
    Where did injury occur?
    (b) Did injury occur in or about the course of his employment? Yes
    Place?
    How did injury occur?
    (c) Signature
    Address

PHYSICIAN

Correct age is especially important. Physicians please write the month and day of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

a. Baltimore City, Maryland

b. Street address 207 N. Caroline

c. Hospital or institution:

d. Length of stay in hospital or inst. yrs., mos., or days

e. Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

a. State Md b. County

c. City or town B.C.

(If outside city or town limits write RURAL and give town)

d. Street No. 1

(If rural give location)

e. Citizen of foreign country? Yes or No

If yes, name country

3 a. FULL NAME MARGARET E. HILLE

3 b. If veteran, name war

3 c. Social Security Account No.

4. Sex Female

5. Color or race White

6 a. Single, married, widowed, or divorced. Widow

6 b. Name of husband or wife Jacob Hille

6 c. If alive, give age years

7. Birthdate of deceased mo., day, yr. Nov 13 1869

8. AGE: Years 79 Months 1 Days 15 If less than one day hr. min.

9. Birthplace Balto

(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Geo Eiler

13. Birthplace Ger

MOTHER 14. Maiden Name Mary Rudesheimer

15. Birthplace Washington D.C.

16 a. Informant Geo A Eichhorn

16 b. Address 501 E Edmondson Ave

17 a. Burial (burial, cremation, or removal)

17 b. Date thereof (month, day, year)

17 c. Cemetery or crematory Holy Redeemer

Location Baltimore

18 a. Funeral director [illegible]

18 b. Address 2008 Eutaw St

19 a. (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1948 4:11 AM

21. I certify that death occurred on the date above stated that I attended deceased from Aug 15 1947 to Nov 26 1948

and that I last saw her alive on Nov 24 1948

Immediate cause of death Coronary Thrombosis.

Duration 2 days

Due to Chronic Myocarditis with arteriosclerosis 1 yrs.

Due to Hypertension & arteriosclerosis "

Other Conditions

(Include pregnancy within three months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, or public place? While at work

(e) Means of injury

23. Signature Jacob M. Miller M.D.

Address 1613 E Baltimore St Date signed 11/28/48

PHYSICIAN

I attended the above-named from [illegible] and last saw [illegible] alive on [illegible]

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
a Baltimore City, Maryland
b Street address 1743 Clarkson St
c Hospital or institution:

d Length of stay in hospital or inst. yrs., mos., or days
e Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
a State Md b County
c City or town Baltimore (If outside city or town limits, write RFD number and name of township)
d Street No. 1743 Clarkson St (If rural, give location)
e Citizen of foreign country? If yes, name country

3 a **FULL NAME** Martin L. Stimmel
3 b If veteran, name war 3 c Social Security Account No.

4. Sex: Male
5. Color or race: White
6 a Single, married, widowed, or divorced: Widwd
6 b Name of husband or wife: Margaret Stimmel
6 c If alive, give age years
7. Birth date of deceased: mo., day, yr. Sept 5 1884
8. **AGE:** Years 64 Months 2 Days 20 If less than one day hr. min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Bartender
11. Industry or business

FATHER
12. Name: Conrad Stimmel
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary ? ?
15. Birthplace: Germany

16 a Informant: Mrs Margaret Stimmel
16 b Address: 1743 Clarkson St
17 a Burial (Burial, cremation, or removal)
17 b Date thereof: Nov 29 (month) (day) (year)
17 c Cemetery or crematory: Oak Lawn
Location: City
18 a Funeral director: Leitch Funeral Home
18 b Address: 2008 Allen Ave
19 a NOV 29 1948 (Date rec'd by registrar) 19 b Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1948 2 P M

21. I certify that death occurred on the date above stated, that I attended deceased from [illegible] to [illegible] and that I last saw h[illegible] alive on [illegible]

Immediate cause of death Uremia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following
a Accident, suicide, or homicide
b Date of occurrence at M
c Where did injury occur? (City or town) (State)
d Did injury occur about home, on farm, in industrial place, in public place? Where at work?
e Means of injury

23. Signature
Address Date signed

PHYSICIAN

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1805 N Port St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. yrs., mos., or days

(e) Length of stay in Baltimore yrs., mos., or days Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore (If outside city or town limits, write (RURAL) and give town)

(d) Street No. 1805 N Port St (If rural, give location)

(e) Citizen of foreign country? Yes — No

If yes, name country

3 (a) **FULL NAME** Mary E Schmidt

3 (b) If veteran, name war —

3 (c) Social Security Account No —

4. Sex F | 5. Color or race Female white | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Otto Schmidt

6 (c) If alive, give age years

7 Birth date of deceased mo., day, yr. Sept 19 1884

8 AGE: Years 62 | Months | Days | If less than one day: hr. min

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At home

MOTHER FATHER

12. Name Geo Murphy

13 Birthplace Md

14. Maiden Name Mary Hall

15. Birthplace Balto

16 (a) Informant Otto Schmidt

(b) Address 1805 N Port St

17 (a) Burial (cremation, or removal) Burial (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Baltimore

18 (a) Funeral director Ulysses Funeral Home

(b) Address 200 Carlton St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27-44 1944 at 1 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 20 1944 to Nov. 27, 1944 and that I last saw her alive on Nov. 27, 1944

Immediate cause of death

Coronary occlusion — Duration Days

Due to Arteriosclerosis — Yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town)

(d) Did injury occur about home, on farm, industrial place, or public place? While at work (Specify)

(e) Means of injury

23. Signature

Address 1611 North Ave Date signed 11-27-

PHYSICIAN

Underline the cause to which death should be taken if multiple causes are stated.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
   a. Baltimore City, Maryland
   b. Street address 1813 N. Monroe St.
   c. Hospital or institution:
   d. Length of stay in hospital or inst. yrs., mos., or days
   e. Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED
   a. State Md. b. County
   c. City or town Baltimore
   d. Street No. 1813 N. Monroe St.
   e. Citizen of Foreign country? Yes or No
   If yes, name country

3. a. FULL NAME Mary Ellen Amon
   3 b. If veteran, name war
   3 c. Social Security Account No.

4. Sex F. 5. Color or race W. 6 (a) Single, married, widowed, or ~~divorced~~

6 b. Name of husband or wife Frank Amon
   6 c. If alive, give age years

7. Birth date of deceased mo., day, yr Aug. 1872

8. AGE: Years 76 Months Days If less than one day hr. min.

9. Birthplace Baltimore (Town, County, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER

12. Name Mary Ellen Lorden

13. Birthplace England

FATHER

14. Name John Lordan

15. Birthplace England

16. a. Informant Mrs. Elizabeth Brennan
    b. Address 1813 W. North Ave.

17. a. Burial (cremation, or removal) b. Date thereof 11/30/48
    Cemetery or crematory Cathedral
    Location: Baltimore

18. a. Funeral director MARTIN FAHEY & SONS
    b. Address 1827 W. NORTH AVE.

19. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1948 at 6:30 P.M.

21. I certify that death occurred on the date above stated (that I attended deceased from 10/14/48 to 11/26/48 and that I last saw him alive on 11/26/48

Cause of death

Chronic Myocarditis
Cerebral Sclerosis

Duration 7 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

PHYSICIAN

(Underline the name to which birth should be charged statistically)

of autopsy

22. If death was due to external causes, fill in the following
    a. Accident, suicide, or homicide
    (b. Date of occurrence at M
    c. Where did injury occur? (City, town, county, state)
    d. Did injury occur about home, on farm, industrial place, in public place? While at work?
    e. Means of injury

23. Signature M.D.

Address Date signed

V S 130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. L

1. PLACE OF DEATH:
   a. Baltimore City, Maryland
   b. Street address
   c. Hospital or institution:
   d. Length of stay in hospital or inst. yrs., mos., or days
   e. Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED
   a. State
   b. City or town
   c. Street No.
   d. Citizen of foreign country? If yes, name country

3. FULL NAME

4. a. Veteran, name war
   b. Social Security Account No. none

5. Color or race | Single, married, widowed or divorced

6. Name of husband or wife

7. Date of birth

8. AGE: Years, Months, Days, If less than one day

9. Birthplace

10. Usual Occupation: Tin can maker

11. Industry or business: Retired

12. Name

13. Birthplace

FATHER

14. Maiden Name

15. Birthplace

MOTHER

16. Informant

17. Address

Burial — Date thereof 12/20/48

Cemetery or crematory

Location Baltimore, Md.

18. Funeral director

Address

19. Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

20. DATE OF DEATH

21. I hereby certify that I attended the deceased from

Immediate cause of death: Cardiac failure — Due to: 3 weeks

Due to: Arteriosclerotic heart disease. — Due to: ?

Other conditions: Emphysema and chronic atheromatic deposites — Due to: ?

PHYSICIAN

Date of operation

Major findings of operation

If autopsy: Horseshoe kidney

If death was due to external causes (violence), fill in the following:

a. Accident, suicide or homicide?

b. Date of occurrence

c. Where did injury occur? (Specify whether at home, farm, factory or other place)

d. How did injury occur?

Manner of injury

I, Signature: David H Maurine, M.D.

Address: Balto City Hospitals — 11-26-48

Correct age is especially important. Physicians, please write out cause of death clearly and legibly supplied. Use

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY WITH UNFADING INK. Each item of information should be carefully supplied. correct age is especially important. Physicians, please write terms of death clearly and legibly.

1. PLACE OF DEATH:
   a. Baltimore City, Maryland
   b. Street address
   c. Hospital or institution
   d. Length of stay in hospital or inst. yrs., mos., or days
   e. Length of stay in Baltimore yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED
   a. State
   City or town
   Street No.
   Citizen of foreign country? If yes, name country

3. FULL NAME

   If veteran, name war

   No. Nelore

4. Sex 5. Color or race Single, married, widowed, or divorced (write)

   Name of husband or wife

   If married, widowed, or divorced, name last husband or wife

7. Birthplace of deceased

8. AGE: Years, Months, Days. If less than one day, hours or minutes

9. Birthplace

10. Usual Occupation
11. Industry or business

MOTHER / FATHER

12. Name
13. Birthplace
14. Maiden Name
15. Birthplace

16. Informant
    Address

17. Burial, cremation, or removal Date thereof
    Cemetery or crematory
    Location

18. Funeral director
    Address

19.

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I hereby certify that I attended deceased from to

    Immediate cause of death

    Contributory (secondary but not related to terminal disease)

    Duration

    Major surgical operations during illness

    Date of operation

    Major findings of operation

    Was autopsy performed?

    Were findings considered in determining cause of death?

    Manner of injury: Accident, Suicide, Homicide

    Date of occurrence

    Where did injury occur? (Specify whether in or about home, farm, factory, street, office building, or other specified place)

    Did injury occur in course of employment?

    Means of injury

    Signature

    Address

    Date signed

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
a. Baltimore City, Maryland
b. Street address
c. Hospital or institution
d. Length of stay in hospital or inst. yrs., mos., or days
e. Length of stay in Baltimore City, yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED
a. State
b. City or town
c. Street No.
d. Citizen of what country?
If yes, name country

3. FULL NAME

4. Usual occupation, nature of work

Social Security No.

5. Sex

6. Color or race

7. If married, widowed or divorced

WIDOWED

WM. S. ARBAUGH

8. AGE

OCT 19, 1878

70 | 10

9. Birthplace WESTMINSTER, CARROLL | MD.

10. Usual Occupation HOUSE WORK

11. Industry or business

MOTHER | FATHER

12. Name SAMUEL WILHIDE

13. Birthplace CARROLL COUNTY MD.

14. Maiden Name LYDIA MILLER

15. Birthplace CARROLL COUNTY MD.

16. Informant MRS ROGER LINDSAY

Address LIBERTY ST. WESTMINSTER, MD.

17. BURIAL Date there DEC. 1, 1948

Cemetery or crematory WESTMINSTER CEMETERY

Location WESTMINSTER, MD.

18. Funeral director J. FRANCIS REESE

Address WESTMINSTER, MD.

19. Filed by registrar

Date

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 '48

21. I attended the deceased from

to

Immediate cause

Due to (b)

Due to (c)

Due to (d)

Contributory causes

Duration

Where did disease occur?

Other significant conditions

PHYSICIAN

Date of operation

Major findings of operation

Was autopsy performed?

Did autopsy confirm diagnosis?

Accident, suicide or homicide?

6. Date of occurrence

Where did injury occur?

7. Did injury occur while at work?

Manner of injury

13. Signature

Address

Date signed 12/4/48

Please write plainly, using ink. Every item is important. The correct age is especially important. The time, place and cause of death should be carefully supplied. The certificate must be filed with the registrar of the district in which death occurred and legal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 910 Harlem Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED

(a) State Md. (b) County

(c) City or town Baltimore

(d) Street No. 910 Harlem Ave.

(e) Citizen of foreign country? (Yes or No) NO

If yes, name country

3 (a) **FULL NAME** Minnie M. Jerrett

3 (b) If veteran, name war No

3 (c) Social Security Account No. No

4. Sex F M

5. Color or race White

6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife William Jerrett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1868

8. AGE: Years 80 Months 6 Days 13 If less than one day hr. min

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant: Mrs. Mabel Black

(b) Address 910 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) Date thereof 11/30/48 (month, day, year)

(b) Cemetery or crematory Westminister

Location Westminister, Maryland

18 (a) Funeral director John T. Stansbury

Address 2700 Edmondson Ave.

19 NOV 29 1948 (Date received by registrar) Turington for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month) (Day) (Year) at (Hour) M

21. I certify that death occurred on the date above stated, that I attended deceased from (Month) (Day) (Year) to (Month) (Day) (Year) and that I last saw h alive on (Month) (Day) (Year)

Immediate cause of death — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

(Underline the cause which is the basic cause of death)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence (Month) (Day) (Year) at (Hour) M

(c) Where did injury occur? (City or town)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)

(e) Means of injury

(f) Signature

Address

6689.7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

6689.7
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 Tissure St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RACHEL SCOTT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/22/1871

8. AGE: Years	Months	Days	If less than one day
77 yrs.	1	3	hr. min.

9. Birthplace Salem, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Manuel Anderson
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice ?
15. Birthplace Maryland

16 (a) Informant: William D. Scott
(b) Address 408 George Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/48 (month) (day) (year)
(c) Cemetery or crematory [illegible] Cemetery
Location Mt. [illegible]

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Avenue

19 (a) NOV 29 1948 (Date rec'd by registrar) (b) Farmington Village, Md. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1948 at 7:30 P M

21. I certify that I took charge of the remains described above, held an Inspection + Inq thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner

Date signed 11-26-48

VS 15t

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6689-8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1002

Registered No. 6689-8

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 - Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 Harlem Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Black

3 (b) If veteran, name war

3 (c) Social Security Account No. unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	W. Married

6 (b) Name of husband or wife Dead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) unknown

8. AGE: Years	Months	Days	If less than one day
72	—	—	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business —

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Rev Holland Brown
(b) Address 1015 - Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director A. Hulsteyn
(b) Address 918 E. Lanvale St

19 (a) NOV 29 1948 (Date received by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 | 23 | 1948, at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 | 20 | 1948 to 11 | 23 | 1948, and that I last saw h alive on 11 | 23 | 1948.

	Duration
Immediate cause of death Congestive Heart failure	
Due to Pulmonary infarction	
Due to Thrombo-phlebitis of femoral vein	
Other Conditions Pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Brady M. D.
Address 1514 - Division St Date signed 11/26/48

VS 150

6689 to 9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 6689 to 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 539 N. CAREY Street
(c) Hospital or institution: 18 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 539 N. CAREY Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie MARIE Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1879

8. AGE: Years	Months	Days	If less than one day
69	4	16	hr. min.

9. Birthplace King William County, VA. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace King William County, VA.

MOTHER
14. Maiden Name ELLA Stewart
15. Birthplace King William County, VA.

16 (a) Informant Annie Hill
(b) Address 4911 Reno st; Philadelphia, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Baltimore

18 (a) Funeral director Wm A Jackson
(b) Address 916 Pelham Ave Funkstown Williamsport, Md.

19 NOV 29 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1948, at 8:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28, 1948. to Nov. 28, 1948, and that I last saw her alive on Nov. 28, 1948.

Immediate cause of death	Duration
CARDIAC Failure	2 Days
Due to Cerebral Hemorrhage	Month
Due to Hypertensive Heart Disease	Several Yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 N. Franklin St. Date signed 11-29-48

VS 150

6897C

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 6897C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1524 E. Biddle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joshua Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Emmaline
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1884

8. AGE: Years	Months	Days	If less than one day
64	9	28	hr. min.

9. Birthplace Bengies, Maryland (Town, county, and state)
10. Usual Occupation Railroad Worker
11. Industry or business Unknown

FATHER
12. Name "
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Harry Cooper
(b) Address 1524 E. Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-45 (month) (day)
(c) Cemetery or crematory
Location Essex MD

18 (a) Funeral director Gray Wilson
(b) Address 1000 Brentley Ave

19 (a) NOV 29 1945 (Date filed by Registrar) (b) Huntington Williams M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 1945 at 3:35 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to sudden death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions Auricular Fibrillation

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert B. McFadden M.D. Medical Examiner
Date signed 11-26-45

68971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

68971 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4001 Glenmore Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS TERESA ENGLAND

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband ~~or wife~~ Wm. L. England
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) JAN 7, 1878

8. AGE: Years	Months	Days	If less than one day
70	10	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John Koenig
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Fisher
15. Birthplace Balto. Md. U.S.A.

16 (a) Informant Wm. L. England
(b) Address 4001 Glenmore Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lazarahn Funeral Home
(b) Address 7101 Belair Rd.

NOV 29 1948 (Date received by Registrar) (By) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1948, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1948 to Nov 28 1948 and that I last saw her alive on Nov 28 1948.

Immediate cause of death	Duration
Cardiovascular failure	
Due to Cerebrosclerotic C-V Disease	?
Due to	
Other Conditions Intestinal obstruction (cause?), Uterine (Include pregnancy within 3 months of death)	
Date of operation None	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury
23. Signature Burnett M. Snelson M D
Address Mercy Hosp. Date signed 11/28/48

VS 150

G68972 C-48-284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G68972

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 McAleer Court
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Alden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 26, 1948

8. AGE: Years	Months	Days	If less than one day
		4	3 hr. 55 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harold Frederick Alden
13. Birthplace

MOTHER
14. Maiden Name Dorothy Loretta Myers
15 Birthplace Baltimore, Maryland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director D. Ruck
(b) Address 5305 Harford Rd

19 (a) NOV 29 1948 (Date received by Registrar) (b) Hunting & Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26, 1948 at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21/ 1948 to 11/26/ 1948, and that I last saw him alive on 11/26/ 1948

Immediate cause of death: Respiratory failure — Duration: 5 min.

Due to aspiration of mucous? — ?

Due to Prematurity

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature James S. Hartke M. D.
Address St. Joseph Date signed 11-26-48

VS 150

68973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

68973 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Columbia, S.A.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Medellin
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country South America

3 (a) FULL NAME Antonio Arrango

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Angelo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): 8-28-96

8. AGE: Years: 52 | Months: 3 | Days: 21 | If less than one day: 29 hr. min.

9. Birthplace: South America (Town, county, and state)

10. Usual Occupation: Real Estate Broker

11. Industry or business

FATHER
12. Name: Pablo Arrango
13. Birthplace: S.A.

MOTHER
14. Maiden Name: Rosa Ochoa
15. Birthplace: S.A.

16 (a) Informant: Lee Cashen
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Transit (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)
(c) Cemetery or crematory Medellin
Location Colombia S.A.

18 (a) Funeral director Wm Cook Inc.
(b) Address 217 St Paul St

19 (a) (b)
(Date rec'd by Registrar) Registrar
NOV. 29 1948 Huntington Hilliard, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948, at 6 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28- 1948, to 11-27-1948
and that I last saw him alive on 11-27-1948

Immediate cause of death	Duration
(1) Congestion of superior renal vein	
Due to (2) Carcinoma, metastatic, ? hypernephroid	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman E Shamer, MD M. D.
Address Johns Hopkins Hospital Date signed 11-27-48

668974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12-1a

668974 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Ave.
(c) Hospital or institution: Bar Wil-Ba Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Low Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a). FULL NAME Robert Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 70 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Unk.

11. Industry or business

FATHER 12. Name Robert Miller, Sr.
FATHER 13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Unk.
MOTHER 15. Birthplace Unk.

16 (a) Informant Mrs. E. Williams
(b) Address 1317 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 30 1948 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary Cemetery
Location Annex Greenbelt Cathy and

18 (a) Funeral director Joseph A. Shipley
(b) Address 661 West Baare Street

19 MAR 2 0 1948 (b) [illegible]
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25th 1948 at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30-1948 to 11-25-1948, and that I last saw h- alive on 11-24-1948.

Immediate cause of death Cardio Vascular Renal Disease - 1 yr. Prostatic hypertrophy

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert L. Jackson, M.D.
Address 600 N. Arlington Ave. Date signed 11-27-48

VS 150

668975

LCH - 124543

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82

668975
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 N. Poppleton Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME RACHAEL FERNANDEZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Ernest
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/12/1901

8. AGE: Years	Months	Days	If less than one day
47	10	13	hr min

9. Birthplace Penn. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Smith (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Isabel Brown
15. Birthplace Maryland

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Retta R. Williams
(b) Address 322 N. Schroeder St

19 Nov 29 1948 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25/48 19 at 3:00 AM PM

21. I certify that death occurred on the date above stated, that I attended deceased from 11/13/48 19 to 11/25/48 19 and that I last saw her alive on 11/25/48 19

Immediate cause of death
CARDIAC FAILURE — Duration ?

Due to
HYPERTENSIVE HEART DISEASE — ?

Due to

Other Conditions
SYRINGOMYELIA
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T Rowan P. Jennings
Address BALTIMORE CITY HOSP. Date signed 11-25-48 M. D.

VS 192

939

668976 C- 48-21272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

668976 Registered No.

A166954 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 LENNOX, ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Frank Morgan
3 (b) If veteran, name war -
3 (c) Social Security Account No. -

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4-22-48
8. AGE: Years | Months: 2 | Days: 5 | If less than one day: hr. min.
9. Birthplace Md. (Balto.) (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Charles Morgan
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret Miller
15. Birthplace Pa.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. - 27 1948 at 3A 15 M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-26-1948 to 11-28-1948 and that I last saw h alive on 11-27-1948.

Immediate cause of death	Duration
Cortical damage	
Due to hyperpyrexia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
Cardiac Failure
of autopsy: Cardiac Enlargement

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. Ryan
Address Johns Hopkins Hosp. Date signed 11/28/48

VS 130

668977

AB-59494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

668977 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 33yrs-

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 Lewis St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Florence Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Edward (D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 19-? 115

8. AGE: Years	Months	Days	if less than one day
73?	1	5	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Joshua Turner (D
13. Birthplace Md.

MOTHER
14. Maiden Name Jane ? (D
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29th 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. Co. Md.

18 (a) Funeral director Bysrout Mamis & W. Knight
(b) Address 727 Aisquith St

NOV 29 1948 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1948, at 6.40P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-25- 1940 to 11-24- 1948 and that I last saw her alive on 11-24- 1948.

Immediate cause of death BRONCHOPNEUMONIA — Duration 10 DAYS

Due to BRONCHIECTASIS — .?

Due to

Other Conditions NEPHROSCLEROSIS. PURULENT PERICARDITIS
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: NONE
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas P. Gerrigan M. D.
Address BALTIMORE CITY HOSP. Date signed 11-25-48

VS 159

107

G68978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

G68978 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner & Dukeland Ave

(c) Hospital or institution: West Baltimore General Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 620 Dumbarton Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary A. Roycroft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Raymond A Roycroft

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21, 1894

8. AGE: Years 54 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Michael Murray

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Kilmartin

15. Birthplace Ireland

16 (a) Informant Raymond Roycroft

(b) Address 620 Dumbarton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-48 (month) (day) (year)

(c) Cemetery or crematory New Catholic Location Old Frederick Rd

18 (a) Funeral director John A Moran

(b) Address 3080 E Baltimore St

19 (a) Nov 29 1948 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27/48 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13/48 19 to 11/27/48 19 and that I last saw her alive on 11/27 19 48

Immediate cause of death Liver failure

Due to cirrhosis?

Metastatic carcinoma?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? None (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work) (Specify type of place)

(e) Means of injury

23. Signature J P Young M. D.

Address W.B.G.H. Hospital Date signed 11/27/48

VS 150

SANDS

668979 **BALTIMORE CITY HEALTH DEPARTMENT** 668979

CERTIFICATE OF DEATH

108 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway at Fremont
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Park Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Linda Sands (Lydia)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: Unknown

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1879

8. AGE: Years 69 | Months 6 | Days 17 | If less than one day: hr. min.

9. Birthplace Norway (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name August Sands

13. Birthplace unknown

MOTHER 14. Maiden Name Nancy ?

15. Birthplace unknown

16 (a) Informant Hospital Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30th 1948 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Leo G. Crook

(b) Address 4703 N. Patterson Park Ave

(c) Nov 29 1948 Huntington Williams, Jr. (Date rec'd by registrar)

WORLD WAR [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1948, at 7:35 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/28 (23) 1948 to 11/28 1948 and that I last saw her alive on 11/28 1948.

Immediate cause of death Pulmonary Edema — Duration

Dilatation of Heart

Hypertrophy of Heart

Due to Arteriosclerotic Heart Disease 10 yrs

Due to

Other Conditions Lobar pneumonia

Left lower lobe, org. unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Confirms above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Lee M. Howard

Address Church Hospital Date signed 11/28/48

VS 153

9 D

668960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81a

668960 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fairfield Ave
(c) Hospital or institution: Univ Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 W. FAYETTE St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie M Gilbert

3 (b) If veteran, name war | 3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. MAY 1- 1879

8. AGE: Years 69 | Months 6 | Days 27 | If less than one day hr. min. 68

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Charles M. Scott
13. Birthplace Balto Md

MOTHER
14. Maiden Name Rose Preston
15. Birthplace Balto, Md

16 (a) Informant Dorothy V. Thompson
(b) Address 1325 W. FAYETTE St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1-1948 (month) (day) (year)
(c) Cemetery or crematory MEADOWRIDGE CEM
Location Howard Co Md

18 (a) Funeral director Robt C & B M. Walker
(b) Address Balto. Stricker St

19 (a) (Date received by registrar) Washington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 48 at 2 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1948 to Nov 18 1948 and that I last saw h alive on Nov 18 1948.

Immediate cause of death	Duration
Peripheral circulatory collapse	8 hours
Due to Meningoencephalomyelitis study undetermined	3 weeks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death.)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Thomas M.D.
Address Univ Hospital Date signed 11/18 M. D.

G68981 ✓ G68981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette & Calhoun Sts

(c) Hospital or institution: Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yrs

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 230 South Stricker St (If rural give location)

(e) Citizen of foreign country? — (Yes or No)

If yes, name country —

3 (a) FULL NAME Charles F. Hall

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 2/27/78

8. AGE: Years	Months	Days	If less than one day
70	9	2	— hr. — min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER	12. Name	John F. Hall
	13. Birthplace	Virginia
MOTHER	14. Maiden Name	Kat Brown
	15. Birthplace	Virginia

16 (a) Informant Hospital Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4-1948 (month) (day) (year)

(c) Cemetery or crematory

Location Mathews Virginia

18 (a) Funeral director Pott & B.M. Walker

(b) Address Pratt & Smith Sts

19 (a) Nov 2 1948 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1948, at 6 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9 1948 to 11/27 1948 and that I last saw him alive on 11/27 1948.

Immediate cause of death Cardiac Failure

Due to Arterio Sclerotic Heart Disease

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 11/29/48

Major findings of operation: Cardiac Arrest

Ulcer probably malignant

Contributes Post death

Duration

PHYSICIAN

(Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury —

23. Signature Maybud R Ramsey M.D.

Address 7 John Hopkins Date signed 11/2

VS 159

668982

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 668982 Registered No.

46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9-1
(c) Hospital or institution: Mercy Hospital Balto. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 68

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town) Baltimore
(d) Street No. 4020 Willsby Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. AGNES M. O'DONNELL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married.

6 (b) Name of husband or wife Charles R O'Donnell.
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) October 10, 1880

8. AGE: Years	Months	Days	If less than one day
68	1	19	hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name Peter Williams
13. Birthplace Austria

MOTHER
14. Maiden Name Christine Muller
15. Birthplace Germany

16 (a) Informant: Charles R. O'Donnell
(b) Address 4020 Willsby Ave. Balto 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director H. H. Weaver and Son
(b) Address 805 N. Calvert St.

19 NOV 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948, at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1948, to Nov 27 1948 and that I last saw h[illegible] alive on Nov 27 1948

Immediate cause of death	Duration
Cardio-Vascular Collapse	
Due to Arteriosclerotic C.V. Disease	
Due to Generalized Cachexia	
Other Conditions Uremia; Intestinal Obstruction; Carcinoma of large Bowel	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Rupert M. Omelee
Address Mercy Hospital Date signed 11/27/48 M D

92D

VS 150

G68983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G68983

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LEAVE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 Freeman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22-4
(e) Length of stay in Baltimore (yrs., mos., or days) About 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Freeman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Marie [redacted] Lampe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Peter Lampe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1849

8. AGE: Years	Months	Days	If less than one day: hr.	min.
99	5 4	10		

9. Birthplace Copenhagen, Denmark (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business —

FATHER
12. Name ? Anderson
13. Birthplace Denmark

MOTHER
14. Maiden Name ? ? Campbell
15. Birthplace Denmark

16 (a) Informant Mrs. Ida F. Lampe
(b) Address 603 Freeman St. Balto 25 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30 1948 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto Md.

18 (a) Funeral director Howard Evans
(b) Address 2200 N. Charles St Balto 18, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 29 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mon., Nov 26, 1948, at 9:55 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1943 to Nov 1948.
and that I last saw her alive on Nov 26 1948.

Immediate cause of death: Generalized carcinomatosis — Duration

Due to primary cancer stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip W. Kuntz, M.D.
Address 3021 Patapsco Ave. Date signed 11/28/48

668984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

668984 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 Laurens St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balte
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Laurens St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Louise Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	married

6 (b) Name of husband or wife Robert Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
38			hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation
11. Industry or business House wife

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Robert Smith
(b) Address 410 Laurens St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-48 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George G. Nelson
(b) Address 1303 Pennsylvania Ave
Huntingtown, Md

19 (a) (Date rec'd by registrar) NOV 29 1948 Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27-48 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1948 to Nov 27 1948.
and that I last saw her alive on Nov 27 1948.

Immediate cause of death Carcinoma of Uterus — Duration Days/Years/Months

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature W. Garland Thrift M. D.
Address 1354 Druid Hill Ave Date signed Nov. 30, 1948

G68985 ✓ G68985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: University Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
2 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 630 W. Saratoga Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME EDDIE ENTZMINGER

3 (b) If veteran, name war WW I

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
50			..... hr. ..... min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business .....

FATHER
12. Name Augusta Entminger
13. Birthplace South Carolina

MOTHER
14. Maiden Name Easter ?
15. Birthplace South Carolina

16 (a) Informant Hattie Diles
(b) Address 1730 Wood St., Richmond, Va.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 12-1-48 (month) (day) (year)
(c) Cemetery or crematory Balto nat'l
Location md

18 (a) Funeral director George B. Kelton
(b) Address 1303 Presstman ST

19 (a) NOV 29 1948 (Date rec'd by registrar) **(b)** [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20, 1948, at 4.05a M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH .....

Contusion of spinal cord.

Due to Fracture of neck.

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary X or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-23-48 at approx. 2.30 p. M.
(b) Where did injury occur? Old Court Rd. Pikesville
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? yes
(d) Means of injury Fell off hayw[illegible]on to street

23. Signature Geo. L. Merrill M.D.
Medical Examiner.
Date signed November 20, 1948

VS 151

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

668986 Registered No. 668986

CERTIFICATE OF DEATH 462

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3407 Barclay St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Georgene Lloyd Henderson

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife William Henderson | 6 (c) If [illegible], give age years

7. Birth date of deceased (mo., day, yr) Aug 27 1899

8. AGE: Years 49 | Months 2 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Charles Lloyd

13. Birthplace Md

MOTHER 14. Maiden Name Emma Gray

15. Birthplace Md

16 (a) Informant Charles Lloyd

(b) Address 3407 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 30 48 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem Park

Location Baltimore Co. Md.

18 (a) Funeral director Wm Francis A Kunsler

(b) Address 578 W Biddle St.

NOV 29 1948 19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26th. 1948 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24th 1948 to Nov. 26th. 1948. and that I last saw her alive on Nov. 24th. 1948.

Immediate cause of death: Carcinoma of the Stomach — Duration: about 6 mos

Due to

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos W Hargett Jr M.D.

Address 401 E. 25th. St. Date signed 11/27/48.

VS 150

G68987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G68987

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 769 Sarah Ann Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 769 Sarah Ann St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EVA M. HOLLIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) September 25 1903

8. AGE: Years	Months	Days	If less than one day: hr.	min
45	2	3		

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Natheria Sykes
13. Birthplace N. C.

MOTHER
14. Maiden Name Annie Wilson
15. Birthplace N. C.

16 (a) Informant Mrs Virginia Hollis
(b) Address 769 Sarah Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1,1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Anne Arundel Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 573 W. Biddle St.

DEC 29 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1948, at 12:45 P

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 1948 to 11/27 1948. and that I last saw he alive on 11/22 1948

Immediate cause of death: Cerebral vascular hemorrhage — Duration 2 days

Due to

Due to Hypertension — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Garner M. D.
Address 253 George St Date signed 11/29/48

VS 150

G68988

BALTIMORE CITY HEALTH DEPARTMENT X V G68968
CERTIFICATE OF DEATH 14
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St. Mary's Co.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Mary's Co. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Genevieve Fenwick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12 1928

8. AGE: Years	Months	Days	If less than one day: hr.	min
20	5	10		

9. Birthplace St. Mary's Co. Md (Town, county and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Fenwick
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Edna Smith
15. Birthplace St. Mary's Co. Md.

16 (a) Informant Christine Fenwick
(b) Address St. Mary's Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-48 (month) (day) (year)
(c) Cemetery or crematory Valley Lee Camp; Location St. Mary's Co. Md.

18 (a) Funeral director Vivo B. Pellington
(b) Address Leonardtown Md.

19 (a) (b)

NOV 29 1948 Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1948 at 104 M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-24 1948 to 11-27 1948 and that I last saw her alive on 11-27 1948.

Immediate cause of death Respiratory failure
Due to Menings - encephalitis
Probable Tuberculosis -
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Highlower M. D.
Address University Hosp Date signed 11-29-48

668989 BALTIMORE CITY HEALTH DEPARTMENT ✓ Reg No 668989

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen'l Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 E. 28th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Anna B. Loewer

3 (b) If veteran, name war: -

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife: Henry G. Loewer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1878

8. AGE: Years	Months	Days	If less than one day
70	6	10	hr. min.

9. Birthplace: New York State (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Frederick Baumgartner
13. Birthplace: Germany

MOTHER
14. Maiden Name: Minnie Kreiger
15. Birthplace: Germany

16 (a) Informant: Mr. Henry G. Loewer
(b) Address: 14841 Elderwood, E. Cleveland, Ohio

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19 (a) NOV 29 1948 (Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 November 1948 at 6 48 M

21. I certify that death occurred on the date above stated, that I attended deceased from 26 Nov 1948 to 26 Nov 1948, and that I last saw h[illegible] alive on 26 Nov 1948.

Immediate cause of death: Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. A. Cerand M. D.
Address Date signed

E. A. Cerand

VS 150

66890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

✓ 66890 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 3708 Brooklyn Ave.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Walter Tillery

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 217-03-0590.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Elsie M. Tillery
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 12, 1877

8. AGE: Years	Months	Days	If less than one day
71	10	15	hr. min.

9. Birthplace: Middlesex Co., Va. (Town, county, and state)
10. Usual Occupation: Stevedore
11. Industry or business

FATHER
12. Name: John Tillery
13. Birthplace: Va.

MOTHER
14. Maiden Name: Eliza Dulaney
15. Birthplace: Ft. McHenry

16 (a) Informant: Mrs. Elsie M. Tillery
(b) Address: 3708 Brooklyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 29 1948 (Date rec'd by registrar) (Huntington Williams M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27-48 (19) at 2.55 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 10-25 1948 to 11-27 1948, and that I last saw him alive on 11-27 1948

Immediate cause of death: Carcinoma of esophagus
Due to:
Due to:
Other Conditions:

(Including pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

7. Duration:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Charles B. MacDonald M.D.
Address: 1213 Eight St. Date signed: 11-27-48

VS 150

68991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

68991

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3909 Bonner Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3909 Bonner Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: BLANCHE M. JOHNSON

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Eugene D. Johnson

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 16, 1877

8. AGE: Years: 71 Months: 9 Days: 11 If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER

12. Name: Edward J. Piquett

13. Birthplace: U. S. A.

MOTHER

14. Maiden Name: Amanda Stansbury

15. Birthplace: Carroll Co., Md.

16 (a) Informant: Mr. William A. Piquett

(b) Address: 2722 Windsor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) NOV 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 27, 1948, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1948 to Nov 27 1948. and that I last saw h-e alive on Nov 7 1948

Immediate cause of death	Duration
Coronary occlusion from thrombosis	about 10 min
Due to Cardiovascular disease	5 Mo
Due to arterio-sclerosis	?
Other Conditions Hypertension	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Walter D. Hulbert M. D.

Address 2220 Garrison Blvd Date signed NOV. 29/48

VS 153

668992

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 668992 Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2812 Keyworth Ave.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Keyworth Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS AUGUST STROHM, Jr.

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-05-7593

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Daisy A. Strohm (nee Utterbaugh) 6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr: Sept. 13, 1881

8. AGE: Years 67 | Months 2 | Days 15 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: Horn Stevens Co.

FATHER
12. Name: Thomas A. Strohm
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Mary Roberts
15. Birthplace: Md.

16 (a) Informant: Mrs. Daisy A. Strohm
(b) Address: 2812 Keyworth Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

NOV 29 1948 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28, 1948 at 5:20a M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 3 1945 to Nov 28 1948. and that I last saw h im alive on Nov 20 1948.

Immediate cause of death	Duration
Cardiac failure —	Suddenly
Due to Cardio Vascular disease	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN (Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Bauman Hood, M. D.
Address 2200 Garrison Blvd Date signed 11/29/48

X

G68993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

✓ G68993 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline

(c) Hospital or ~~XXXXXXX~~ St. Joseph's 7-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 624 N. Collington Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hellman, Edgar Arthur

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1886

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	3	26 27		

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Schreiber Bro.

FATHER 12. Name Henry J. Hellmann

13. Birthplace Balto., Md.

MOTHER 14. Maiden Name Caroline Louise Blaney

15 Birthplace Baltimore, Md.

16 (a) Informant Mrs. Irene M. Sessions

(b) Address 130 Oaklee Village

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)

(c) Cemetery or crematory Greenmount Mausoleum

Location Baltimore, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1948, at 12:00 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12, 1948, to Nov. 27, 1948, and that I last saw him alive on Nov. 27, 1948.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Acute lymphatic leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation November 15, 1948

Major findings of operation: Ischio-rectal abscess

of autopsy: None

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?

(e) Means of injury

23. Signature J. Joseph Krajci, M.D.

Address 1400 N. Caroline St. Date signed 11-27-48

VS 150

X

68994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 68994

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert streets

(c) Hospital or institution: Union Memorial Hospital 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 827 Northern Parkway, Baltimore 2 (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mildred A. Bradley Habercam

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John H. Habercam

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1902

8. AGE: Years	Months	Days	If less than one day
45	11	27	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation housewife

11 Industry or business

FATHER 12. Name Albert C. Bradley

13. Birthplace Maryland

MOTHER 14. Maiden Name Geneviere Gill

15 Birthplace Maryland

16 (a) Informant Union Memorial Hospital records

(b) Address 33rd Street, Baltimore Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem. Balto., Md.

Location

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

NOV 29 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1948, at 4:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1948. to Nov. 26 1948, and that I last saw h er alive on Nov. 26 1948.

Immediate cause of death	Duration
Carcinoma, rt. Breast	
Due to mets	
Due to	
Other Conditions multiple thrombi	
L. auricle	

(Include pregnancy within 3 months of death)

Date of operation Nov. 18, 1948

Major findings of operation: Carcinoma right breast with L. axillary metastases

of autopsy: Negative

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles N. Watt, J. M. D.

Address Union Memorial Hospital Baltimore 18, Md. Date signed 11/27/48

X

VS 1M

BC-48-25910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G68995

Registered No. G68995

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Eager Sts

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4010 Maine Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby (fem) Leroy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/26/48

8. AGE: Years | Months | Days | If less than one day: 1 hr. 30 min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Melvin E. LeRoy
13. Birthplace Philadelphia Pa.

MOTHER
14. Maiden Name Mary D. Sutecki
15 Birthplace Maryburg, Wis.

16 (a) Informant Hosp. Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-48 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director Wiedefeld & Son
(b) Address 1948 Greenmount & 20th

19 NOV 29 1948 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948 at 2:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/26/ 1948 to 11/27 1948, and that I last saw her alive on Nov. 27 1948.

Immediate cause of death: Premature

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify home, farm, etc.) While at work?

(e) Means of injury

23. Signature T. Sieniski

Address Mercy Hosp. Date signed 11/28/48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 668996

668996

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 McKewin Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 McKewin Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Harrison Quade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian V. Quade
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1890

8. AGE: Years	Months	Days	If less than one day
58	10	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Operator
11. Industry or business Motion Picture

FATHER
12. Name Alex Quade
13. Birthplace Maryland

MOTHER
14. Maiden Name Madora Dean
15. Birthplace Maryland

16 (a) Informant Mrs Lillian V. Quade
(b) Address 611 McKewin Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director John G. Morap
(b) Address 3600 E. Balt. St.

19 (a) NOV 29 1948 (Date filed by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Nov. 1948 at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948 to 27 Nov. 1948 and that I last saw him alive on 26 Nov. 1948.

Immediate cause of death Adenocarcinoma of Stomach — Duration 8 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug. 20, 1948

Major findings of operation: Pyloric obstruction due carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, etc.)
(e) Means of injury

23. Signature Wm. N. Kammerer M.D.
Address 501 Sheridan Ave. Date signed 29 Nov. 48

X

G68997

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G68997
Registered No.

FILE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3526 Roland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3526 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Grant Michael.

3 (b) If veteran, name war ———

3 (c) Social Security Account No. 217-12-2824

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White.	Widowed.

6 (b) Name of husband or wife Mary L. Michael.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1864

8. AGE: Years	Months	Days	If less than one day
84	-	21	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Stationery Engineer.
11. Industry or business Western Maryland Dairy

FATHER
12. Name George W. Michael.
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Coleman.
15. Birthplace Md.

16 (a) Informant Mrs Blanche Mayes.
(b) Address 3526 Roland Ave.

17 (a) Burial. (b) Date thereof Nov. 30, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Ave.

18 (a) Funeral director Paul E. Chenoweth Jr.
(b) Address 3615-17 Cheatnut Ave.

NOV 29 1948 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948 at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1948 to Nov 23 1948 and that I last saw him alive on Nov. 23 1948

Immediate cause of death	Duration
Hypertensive Heart disease	?
Due to Arterio Sclerosis	?
Due to	
Other Conditions Marked cardiac Hypertrophy	?

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Carl A. Rostberg M. D.
Address 1326 W Lombard Date signed 11/27/48

G68998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G68998 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette & Caroline Sts

(c) Hospital or institution: Franklin Square Hosp. 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1717 W 36th St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Georgeanna Reisinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	(M)

6 (b) Name of husband ~~or wife~~ Henry B Reisinger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 7, 1869

8. AGE: Years	Months	Days	If less than one day
79	4	22	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Practical Nurse

11. Industry or business

FATHER 12. Name Bartholomew McCubbin

13. Birthplace Md.

MOTHER 14. Maiden Name Rachel Shankpoole

15. Birthplace Pa.

16 (a) Informant Chas J Lewis

(b) Address 717 W-36 St. (Son)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-48 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill

Location York Pa

18 (a) Funeral director Shumaker Funeral Home

(b) Address 215-17 Chestnut Ave

19 (a) NOV 29 1948 (Date rec'd by registrar) (b) Carrington Williams, Registrar

VS 133

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1948, at 7:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1948, to 11/29 1948, and that I last saw her alive on 11/27 1948.

Immediate cause of death Cerebral Thrombosis — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Bobby L. Lewis M. D.

Address Franklin Square Hosp. Signed 11/29/48

X

G68999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G68999 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2729 N. CALVERT

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 2729 N. CALVERT ST. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME NANNIE HOPKINS MORTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	WIDOWED

6 (b) Name of husband or wife THEODORE J. MORTON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) OCT. 27, 1860

8. AGE: Years	Months	Days	If less than one day
88	1	0	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER

12. Name JOSEPH HOPKINS

13. Birthplace MARYLAND

MOTHER

14. Maiden Name NANNIE RYAN

15. Birthplace VIRIGINIA

16 (a) Informant CHARLES C. MORTON

(b) Address 2729 N. CALVERT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11 30 '48 (month) (day) (year)

(c) Cemetery or crematory GREENMOUNT

Location BALTO., MD.

18 (a) Funeral director HENRY W. JENKINS & SON

(b) Address 4905 YORK RD.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 29 1948 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1948, at 10 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 24 1948, to Nov. 27, 1948, and that I last saw her alive on Nov. 27 1948

Immediate cause of death Myocardial Failure — Duration 3 days

Due to Chronic Myocarditis — Duration months.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury —

23. Signature Frank N. Ogden M. D.

Address 2701 N. Calvert St. Date signed Nov. 29, 48.

G65000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

G63000

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton + Wilkens ave

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1024 Wilmington ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Peter S. Hynson.

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 212-10-8751

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M. W.

6 (b) Name of husband or wife Anna Hynson

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) April-16-1892

8. AGE: Years	Months	Days	If less than one day
56	7	10	hr. min.

9. Birthplace Baltimore md (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired.

FATHER

12. Name Frederick Hynson

13. Birthplace Md Dead

MOTHER

14. Maiden Name Anna Elm

15. Birthplace Md Dead

16 (a) Informant Son.

(b) Address 1024 Wilmington ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Md

18 (a) Funeral director J. D. Nugent & Son

(b) Address 865 W. Baltimore St

19 (a) Dec 2 1948 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS (3)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 26 1948 at 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20- 1948, to 11-26 1948, and that I last saw him, alive on 11-25 1948

Immediate cause of death Congestive Heart Failure — Duration

Due to Arteriosclerotic C-V-Disease

Due to Coronary Insufficiency

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edsel G. Rodkey M.D.

Address St. Agnes Hospital Date signed 11-29-48

G-69000½ B.C. 48-28847

G-69000½

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1519 Division Street

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 1112 Orleans St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Cook

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Provident Hospital (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name

13. Birthplace

MOTHER: 14. Maiden Name

15 Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

16 (a) Funeral director

(b) Address

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 1948 at 8 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/17 1948 to 11/19 1948.

and that I last saw him alive on 11/19 1948.

Immediate cause of death Cardiac Insufficiency — Duration

Due to 3 Chamber Heart

Due to Dextrocardia Absence of anus

Other Conditions Intestinal Obstruction Meckels Diverticulum

(Include pregnancy within 3 months of death)

Date of operation 11/18/48

Major findings of operation: Absence of anus Intestinal obstruction Meckels Diverticulum 3 chamber heart

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify two of these)

(e) Means of injury

23. Signature Dr Marcus N. Moore M.D.

Address Provident Hospital Date signed 3/30/49

X

G69001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. G69001

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ~~2300 PENNA~~ 2300

(c) Hospital or institution: MARYLAND GENERAL HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9YRS, 6MOS, 27DAYS

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County BALTIMORE

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 410 POPLAR GROVE ST. (If rural give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MRS. FLORENCE E. ENEY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 27, 1859

8. AGE: Years 89 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name WILLIAM MALLONEE

FATHER 13. Birthplace BALTIMORE

MOTHER 14. Maiden Name CAMELA ROBINSON

MOTHER 15. Birthplace MARYLAND

16 (a) Informant NELLIE V. ENEY - DAUGHTER

(b) Address 410 POPLAR GROVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto. Md.

18 (a) Funeral director Geo. A. Beyer Jr.

(b) Address 1512 Hollins St.

19 (a) Date received (b) (Registrar)

Huntington Williams M.D.

CX 29

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 NOVEMBER 1948, at 2 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 01 OCT 1948 to 25 NOV 1948, and that I last saw HER alive on 25 NOV 1948.

Immediate cause of death	Duration
CARDIO RESPIRATORY FAILURE	15 hours
Due to CEREBRAL HEMORRHAGE	9YRS
Due to HYPERTENSIVE CARDIO VASCULAR DISEASE	18YRS
Other Conditions GENERALIZED ARTERIOSCLEROSIS (Include pregnancy within 3 months of death)	

Date of operation NONE

Major findings of operation:

of autopsy: NONE

PHYSICIAN: Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Donald J. England M. D.

Address Maryland Gen. Hosp. Date signed 25 Nov 48

669002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669002

82a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5941 Falls Road

(c) Hospital or institution:

27-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5941 Falls Road (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Howard M. Bryan, Sr.

3 (b) If veteran, name war --

3 (c) Social Security Account No. 215-22-7974

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Josephine Bryan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 15, 1876

8. AGE: Years	Months	Days	If less than one day: hr.	min
72	1	14		

9. Birthplace Baltimore Co., Maryland (Town, county, and state)

10. Usual Occupation Overseer

11. Industry or business Mrs. M. A. Long

FATHER

12. Name Edgar Bryan

13. Birthplace Maryland

MOTHER

14. Maiden Name Emma A. Hook

15. Birthplace Maryland

16 (a) Informant Ebert J. Bryan

(b) Address 1312 Asbury Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2, 1948 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) Date rec'd by Local Registrar NOV 29 1948

(b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH November 29, 1948, at 7.15 M

21. I certify that death occurred on the date above stated, that I attended deceased from 1932 to 11-29 1948.

and that I last saw h alive on 11-27 1948.

Immediate cause of death

1. Hypertension

2. CEREBRAL HEMORRHAGE

Duration 2 yrs ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)

(e) Means of injury

23. Signature H. O. Hardman M.D. M.D.

Address East Read St. Date signed 11-29-48

669003

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

927

669003
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3030 Keswick Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 Keswick Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Sarah E. Hampshire

3 (b) If veteran, name war —
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John W. Hampshire
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1863

8. AGE: Years	Months	Days	If less than one day: hr.	min
85	4	18		

9. Birthplace Baltimore Co., Maryland
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Nelson Price
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth --
15. Birthplace Maryland

16 (a) Informant John H. Hampshire
(b) Address 702 W. Joppa Road, Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Grace Methodist
Location Black Rock Road, Baltimore Co.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) 19[illegible] Huntington Williams, M.D. Registrar
(b) (Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1948, at 7 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 8 1948 to Nov. 27 1948, and that I last saw her alive on Nov 27 1948

Immediate cause of death: Myocardial insufficiency
Due to: Arteriosclerosis
Due to: Cardiac disease

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature H. Smith. M.D.
Address 342 Chestnut St. Date signed 11/29/48

VS 150

G65904 ✓ G65904 Registered No.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9-27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 North Spring Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PRYMAS KELLY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lela

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1885

8. AGE: Years 63 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Steel Mill

FATHER
12. Name George Kelly
13. Birthplace Virginia

MOTHER
14. Maiden Name Sarah Kelly
15. Birthplace ~~Kelly~~ KENTUCKY

16 (a) Informan: Lela Kelly
(b) Address 1310 N. Spring Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location C. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

(a) 9 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26, 1948 at 1:07 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Heart Failure

Due to A. S. C. V. D.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature Earl L. Riggs M.D. (Medical Examiner)

Date signed 9-27-48

VS 151

G69005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G69005

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1910 W. Fayette ave & Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 81 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 W. FAYETTE ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME James HERMON CRAIG

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOWED
6 (b) Name of husband or wife: Virginia R. Craig
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) JUNE 7, 1867
8. AGE: Years 81 | Months 5 | Days 20 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business Ches. & Maine R. R.

FATHER
12. Name JAMES W. CRAIG
13. Birthplace MARYLAND

MOTHER
14. Maiden Name JULIA A. COOK
15. Birthplace MARYLAND

16 (a) Informant MRS. VIRGINIA HOOKER
(b) Address 1910 W. FAYETTE ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 NOV 29 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27 1948, at 1345 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23 1948, to 11/27 1948, and that I last saw him alive on 11/27 1948.

Immediate cause of death	Duration
CARDIAC DECOMPENSATION	
Due to AURICULAR FIBRILLATION	
Due to ARTERIOSCLEROTIC C. V. DISEASE	
Other Conditions malignant lymphoma (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: malignant lymphoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul G. Herold M. D.
Address Md. Gen. Hospital Date signed 11/27/48

VS 150

G66006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G66006
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3142 Baker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3142 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** MARY NOWLIN DESOR

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a). Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife August William Desor, Jr. 6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr. Jan. 16, 1892

8. AGE: Years	Months	Days	If less than one day
56	10	12	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Henry Hook
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Minnie Henneger
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Charles J. Wenck
(b) Address 3142 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 29 1948 (Must not be earlier than) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28, 1948 at 3:45a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1931 to Nov. 28, 1948. and that I last saw her alive on 11-27- 1948

Immediate cause of death	Duration
Hypertensive Cardio-vas-cular Renal Disease	17 years
Due to	
Due to	
Other Conditions Diabetes Mellitus	12 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. A. Grossman M. D.
Address 1109 N. Calvert St Date signed 11-29-48

VS 150

121a

G65007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G65007

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 209 Club Road

(c) Hospital or institution: none

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 209 Club Road (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME G. Howard Lentz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ada Waddington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 3, 1880

8. AGE: Years	Months	Days	If less than one day
68	1	25	hr. min

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Wholesale dealer,

11. Industry or business Cigar leaf tobacco

FATHER 12. Name George W. Lentz

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Anna Gottert

15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Mary Lentz Seely

(b) Address Solomon's, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)

(c) Cemetery ~~Greenmount~~ Druid Ridge

Location Pikesville, Maryland

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) NOV 29 1948 (Registered by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1948 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec. 16 1945 to Nov. 28 1948 and that I last saw him alive on Nov 28 1948

Immediate cause of death Arteriosclerotic cardio renal disease — Duration 4 yrs.

Due to Arteriosclerosis - generalized

Due to

Other Conditions Coronary occlusion - old.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature C. Holmes Boyd, M.D.

Address 24 E. Eager St. Date signed 11/29/48

VS 150

G65008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G65008

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mabison & Linden Ave.
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 S. Spring Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Elizabeth Irwin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	

6 (b) Name of husband ~~or wife~~ Marshall Irwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 27 Feb 1872

8. AGE: Years	Months	Days	If less than one day
76	9	2	hr. min.

9. Birthplace Webster Spring W. Va. (town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Payne
13. Birthplace Webster Spring W. Va.

MOTHER
14. Maiden Name Nancy Miller
15. Birthplace Webster Spring W. Va.

16 (a) Informant Mrs Ruth Peterman
(b) Address 5727 Newhaven Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/1948 (month) (day) (year)
(c) Cemetery or crematory Family Plot
Location Webster Spring W. Va.

18 (a) Funeral director Frank Pelz & Son
(b) Address 322 N. Howard St.

NOV 29 1948 (Date received by registrar) (Transcription from Milwaukee, Wis.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Nov. 1948 at 12:29 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Sept 1948 to 29 Nov 1948. and that I last saw her alive on 29 Nov 1948

Immediate cause of death Carcinomatosis (origin unknown)

Due to

Due to

Other Conditions Chr. myocarditis

(Include pregnancy within 3 months of death)

Date of operation 10/6/48; 11/15/48

Major findings of operation: Emphysema gall bladder; Ca met. in liver

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. T. McMorgan M. D.
Address Md. Gen. Hosp. Date signed 29 Nov 1948

VS 150

G69009 ✓ G69009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12-1a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital 29-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 Richwood Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country .....

3 (a) FULL NAME GEORGE BREWER MAYO

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Minnie R. Mayo
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9/12/81

8. AGE: Years	Months	Days	If less than one day
67	2	16	hr. ..... min. .....

9. Birthplace Annapolis South River, A.A. County, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Machinist

FATHER
12. Name James Mayo
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Brewer
15. Birthplace Maryland

16 (a) Informant Mr. Calvin D. Mayo
(b) Address 1520 Clarkston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff Cemetery
Location Annapolis, Md.

18 (a) Funeral director E.W. Lamourne
(b) Address 1003 W. Baltimore St.

19 (Date rec'd by registrar) NOV 29 1948 Clayton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1948 at 8 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1948 to Nov 28, 1948 and that I last saw h, alive on Nov 28, 1948.

Immediate cause of death	Duration
Respiratory Failure	
Due to Uremia	
Due to Chronic Glomerular Nephritis.	
Other Conditions Arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation .....
Major findings of operation: .....
of autopsy chronic glomerular nephritis arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Frank W. Bibo, Jr. M.D.
Address St. Joseph's Hosp. Date signed 11/28/48

VS 150

66010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

66010

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 45 days

(e) Length of stay in Baltimore (yrs., mos., or days): 46 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Norway (b) County:

(c) City or town: Sandfjord (If outside city or town limits, write RURAL and give town)

(d) Street No.: Muviokon (If rural give location)

(e) Citizen of foreign country? yes (Yes or No)

If yes, name country: NORWAY

3 (a) FULL NAME: LIEF NORMAN FJILSTAD

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: -- --

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie Fjildstad

6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): July 5, 1893

8. AGE: Years: 55 | Months: 4 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Norway (Town, county, and state)

10. Usual Occupation: Chief Engineer

11. Industry or business: Seafarer

FATHER

12. Name: Dorothea Anderson

13. Birthplace: Norway

MOTHER

14. Maiden Name: Anton Fjildstad

15. Birthplace: Norway

16 (a) Informant: Records

(b) Address: US Marine Hospital

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12 2 48 (month) (day) (year)

(c) Cemetery or crematory: Druid Mount

Location: Baltimore Md

18 (a) Funeral director: Williams & Son

(b) Address: 129 E Pratt Lexington Williams, Md

19 (a) NOV 30 1948 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29 1948 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1948 to Nov. 29 1948. and that I last saw h im alive on Nov. 29 1948.

Immediate cause of death: Cardiac insufficiency — Duration: unknown

Due to: Arteriosclerotic heart disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: Ray Howard M.D.

Address: U S Marine Hosp Date signed: 11/29/48

VS 150

66011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

66011 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3736 BROOKLYN AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3736 BROOKLYN AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BERTHA DARLING GEORGE

3 (b) If veteran, name war —

3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife JOSEPH GEORGE

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) JULY 28, 1903

8. AGE: Years	Months	Days	If less than one day
45	3	29	hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name JOHN ULRICK
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY BUTLER
15. Birthplace MARYLAND

16 (a) Informant MR. JOSEPH GEORGE
(b) Address 3736 BROOKLYN AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST

19 (a) NOV 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26, 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1946 to Nov 26 1948 and that I last saw her alive on Nov 26 1948.

Immediate cause of death Myocardial degeneration. — Duration

Due to

Due to

Other Conditions Valvular Endocarditis & nephritis.

(Include pregnancy within 3 mos. of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) (While at work)
(e) Means of injury

23. Signature John F. Schemmel M.D.
Address 1337 S Clinton St Date signed 11/26/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69012

On Hospital Disposal 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town, write RURAL and give town)
(d) Street No. 2009 Clifton Ave (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-17-48

8. AGE: Years | Months | Days 8 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial, cremation, or removal (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) NOV 20 1948 (Date received by registrar) (b) Cruttington Williams M.D. (Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20 1948, at 6.45a M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-17 1948, to 11-25 1948, and that I last saw h alive on 11-25 1948.

Immediate cause of death — Duration

Pulmonary congestion.

Due to
Cardiac failure

Due to
Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Young M. D.
Address Johns Hopkins Hosp. Date signed 11-25-48

VS 150

66013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 66013

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 N. Gay Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: SWANNIE SNEED

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Susie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1909

8. AGE: Years 39 39 | Months 5 7 | Days 5 4 | If less than one day hr. min.

9. Birthplace: Durham, NC. (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Edward Sneed
13. Birthplace: N.C.

MOTHER
14. Maiden Name: Alcie Moss
15. Birthplace: N.C.

16 (a) Informant: Susie Sneed
(b) Address: 1212 N. Gay St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: 12 3 48 (month) (day) (year)

(c) Cemetery or crematory: Durham, N.C.
Location

18 (a) Funeral director: MRS. ROBT. A. ELLIOTT & DGTR.
(b) Address: 1129 N. Caroline St.

19 (a) NOV 30 1948 (Date rec'd by registrar) (b) [illegible]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 1948 at 10:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: George G. Merrill M.D. Medical Examiner. DJM
Date signed 11-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 6[illegible]014

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2126 Pennsylvania Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Lipscomb

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-3077

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-27-1892

8. AGE: Years 56 | Months 7 | Days 0 | If less than one day: hr. min.

9. Birthplace Jeffersville, Va. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Jacob Lipscomb
13. Birthplace Va.

MOTHER
14. Maiden Name
15. Birthplace Va.

16 (a) Informant Levi Lipscomb
(b) Address 2543 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles F. Love
(b) Address 802 Madison Ave Huntington Williams, M.D.

19 NOV 30 1948 (b) Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948, at 3:55 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage

Due to Hypertensive cardiovascular disease.

Other Conditions Acute alcoholism
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributory [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in factory, or other place, or public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed November 27, 1948

X

66015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66015
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1909 E.Lafayette Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 49 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 E.Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Fell

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: ?

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia Frances Minnich
6 (c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Sept.10th., 1874

8. AGE: Years: 74 | Months: 2 | Days: 8 | If less than one day: ########## hr. min.

9. Birthplace: Glenville, West Virginia
(Town, county, and state)

10. Usual Occupation: Retired, Bookkeeper & C.P.A.

11. Industry or business

FATHER
12. Name: Wesley S.Fell
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Mary Adore McGee
15. Birthplace: West Virginia

16 (a) Informant: Mrs.Julia Frances Fell--- Wife
(b) Address: 1909 E.Lafayette Avenue, Balto:Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec.2, 1948 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cemetery
Location: Edmondson Avenue, Balto:Md.

18 (a) Funeral director: George J.Kuth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) NOV 30 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29th., 1948, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1948. to Nov 30 1948.
and that I last saw h alive on Nov 30 1948.

Immediate cause of death: Bronchial Pneumonia — Duration: 1 week

Due to:

Due to:

Other Conditions: Hemiplegia, Right side — Duration: 6 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Ruth of Fowler M.D.

Address: 1826 N. Mon — Date signed: Dec 2

107

66016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66016
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2927 Hammonds Ferry Rd. Lansdowne
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosaria ~~D'Anna~~ LOMBARDI D'ANNA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married mid.

6 (b) Name of husband or wife late Salvatore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10 1875

8. AGE: Years	Months	Days	If less than one day
73	11	17	hr. min.

9. Birthplace Palermo Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Roberto Nicolicchia
13. Birthplace Italy

MOTHER
14. Maiden Name Vincenza ?
15. Birthplace Italy

16 (a) Informant Concetta Mogavero
(b) Address 2927 Hammonds Ferry Rd. Lansdowne

17 (a) Burial (b) Date thereof Nov. 30/48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodbridge Memorial
Location

18 (a) Funeral director Francis Dallas Lucas
(b) Address 322 S. High St.

19 (a) NOV 30 1948 (b)
(Date rec'd by registrar) Lansdowne, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948 at 5.40 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 27 1948 to Nov. 27 1948, and that I last saw him alive on Nov. 27 1948

Immediate cause of death Respiratory failure — Duration

Due to Cerebral Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. C. Hunter, M.D.
M. D.
Address Univ. Hosp. Date signed 11 27 48

VS 53

16:0:7 BALTIMORE CITY HEALTH DEPARTMENT 16:0:7

CERTIFICATE OF DEATH

Registered No. 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL, and the town)
(d) Street No 1613 Rickenbacker Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Schultz
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	M.

6 (b) Name of husband or wife Agnes
6 (c) If wife, give age 58 years
7. Birth date of deceased (mo., day, yr.) 8-13-83

8. AGE: Years	Months	Days	If less than one day: hr	min.
65 66	3	16		

9. Birthplace New York (town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Robert Schultz
13. Birthplace Russia

MOTHER
14. Maiden Name Amelia ?
15. Birthplace Russia

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30, 1948 (month) (day) (year)
(c) Cemetery or crematory
Location New York City, N.Y.

18 (a) Funeral director Roland E. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) Date rec'd by registrar Dec 2 1948 (b) Registrar Hilliard Williams M.D.

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1948 at 8 20a M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/22 1948 to 11/29 1948 and that I last saw h[illegible] alive on 11/29 1948

Immediate cause of death Metastatic Carcinoma of tail of Pancreas — Duration

Due to

Due to

Other Conditions ASCVD • HCVD-[illegible]

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Extensive metastases to peritoneum of stomach by Carcinoma of Pancreas

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Jackson M. D.
Address The John Hopkins Hosp. Date signed 11/29/48

3018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66078 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince George
(c) City or town Laurel (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 9th St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Brooks
3 (b) If veteran, name war V
3 (c) Social Security Account No. 212-14-5297
4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Adeline Brooks
6 (c) If alive, give age years
7. Birth date of deceased mo., day, yr. June 6 1884
8. AGE: Years 64 | Months 5 | Days 23 | If less than one day hr. min
9. Birthplace Howard Co Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Edward Brooks
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Howard
15. Birthplace Maryland

16 (a) Informant: Catherine Gibson
(b) Address Laurel R. F. D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2 1948 (month) (day) (year)
(c) Cemetery or crematory Bacon Chapel
Location Anne Arundel Co Near Laurel

18 (a) Funeral director Ridgley Selby
(b) Address 401 Washington Blvd Laurel Md

19 (a) NOV 30 1948 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1948 at 2 3/4 M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-27 1948 to 12-27 1948 and that I last saw h[illegible] alive on 12-24 1948

Duration

Immediate cause of death Respiratory Paralysis
Due to Bronchopneumonia
Due to Erythema Multiforme
Other Conditions Arteriosclerotic
(including pregnancy within 3 months of death)

PHYSICIAN
Underline the cause to which death should be charged statistically

Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address 42-24 University Pkwy 107
Date signed 12-27 1948 M. D.

VS 159

G65019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G650 19
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully reported. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 142 W Hennetta
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 142 W Hennetta St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Pollard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4/13/1890

8. AGE: Years 58 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Phoebus Va (Town, county, and state)

10. Usual Occupation D

11. Industry or business

MOTHER | FATHER
12. Name Bebe Clark
13. Birthplace Va
14. Maiden Name unknown
15. Birthplace ?

16 (a) Informant William R Clark
(b) Address 530 Sanford Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park
Location Balto County

18 (a) Funeral director Daniel L Brown & Son
(b) Address 108 W Montgomery St

NOV 30 1948 (Date received by registrar) (b) [illegible] Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28/48 19 . at 3:4 M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 26 19 48 to Nov 28 19 48 and that I last saw h[illegible] alive on Nov 27 19 48

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 wks
Due to: Hypertension — ?
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph B Gross M. D.
Address 140 Eastern Ave Date signed Nov 29 1948

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4301 ROLAND AVE.

(c) Hospital or institution: KIRKLEIGH VILLA

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 YEAR

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MARYLAND (b) County

(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)

(d) Street No. 4301 ROLAND AVE (If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME MARY THRESA BOSWELL.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-8-1865

8. AGE: Years	Months	Days	If less than one day
83	8	21	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name FREDERICK C. BOSWELL

13. Birthplace HANOVER, GERMANY

MOTHER 14. Maiden Name ANNA M. FASNACHT

15. Birthplace MD.

16 (a) Informant HOSPT. RECORDS

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12 2 48 (month) (day) (year)

(c) Cemetery or crematory ST. MICHAELS

Location CLEARSPRING, MD.

18 (a) Funeral director KRAISS FUNERAL HOME

(b) Address HAGERSTOWN, MD.

19 (a) NOV 30 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 29 1948 at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 1 1948 to NOV 29 1948, and that I last saw her alive on NOV 29 1948.

Immediate cause of death	Duration
CARCINOMIA OF INTESTINES NOV	1 1948
CHRONIC MYOCARDITIS	1948.
Due to	
CHR INTERSTITIAL NEPTHRITIS	1948
Due to	
ARTERIOR SCLEROSIS	1948.

Other Conditions: SENILITY

(Include pregnancy within three months of death)

Date of operation NONE

Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Chas. T. Williams

3013 ST PAUL STREET NOVEMBER 30 1948

Address Date signed

VS 15)

665021

JL- 124282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 665021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days

(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2126 Howard St. (If rural give location)

(e) Citizen of foreign country? Yes or No

If yes, name country

3 (a) FULL NAME Virginia Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Ernest

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 19, 1921

8. AGE: Years	Months	Days	If less than one day
27	10	9	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Foster Brooks

13. Birthplace Va.

MOTHER 14. Maiden Name Eliza Griffin

15. Birthplace Va.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/48 (month) (day) (year)

(c) Cemetery or crematory MT Auburn

Location Balto City

18 (a) Funeral director Karl Jackson

(b) Address 916 Penna Ave

19 (a) NOV 30 1948 (Date rec'd by registrar) (b) undertaker for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1948, at 11:45 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1948, to Nov. 28 1948, and that I last saw her alive on Nov. 28 1948.

Immediate cause of death Bilat bronchopneumonia — Duration 2 wks

Due to Resp paralysis

due to a cute porphyria

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. T. Wilson M.D.

Address BCH Date signed 11-29

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 D.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore – 24 (If outside city or town limits, write RURAL, and give town)

(d) Street No. 3422 Leverton Ave (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Catherine Whichard (CATHERINE WHICHARD)

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John L. Wichard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 21, 1903

8. AGE: Years: 44 | Months: 11 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business:

FATHER 12. Name: John Barton

FATHER 13. Birthplace: — Maryland

MOTHER 14. Maiden Name: Katie Wachsmuth

MOTHER 15. Birthplace: Maryland

16 (a) Informant: Hospital Records

(b) Address: MERCY HOSPITAL, Balto., MD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/48 (month) (day) (year)

(c) Cemetery or crematory: MOUNT CARMEL

Location: BALTIMORE, MD.

18 (a) Funeral director: HENRY SANDER & SONS, INC.

(b) Address: NORTH AVE. & BROADWAY

19 NOV 30 1948 (Date rec'd by registrar) Number for [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 27 1948 at 10:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1948 to Nov. 27 1948 and that I last saw her alive on Nov. 27 1948.

Immediate cause of death: Multiple arterial emboli — Duration:

Due to: Mitral valve thrombi — Duration:

Due to: Mitral stenosis, Left ventricular hypertrophy — Duration:

Other Conditions: Arteriosclerosis Hypertension

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)

(e) Means of injury

23. Signature: T. Siwinski M.D. M. D.

Address: Mercy Hosp. Date signed: 11/27/48

VS 156

669023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 669023

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 740 N. Linwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 740 N. Linwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL MARION PEACOCK

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. (Smith)

6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Nov. 12, 1870

8. AGE: Years: 78 | Months: 0 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Wholesale Seafood

FATHER
12. Name: George Peacock
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: ?
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Mary E. Peacock- Widow
(b) Address: 740 N. Linwood Avenue -5

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) (Registrar)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH: Nov. 29 1948, at 10.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1948 to 11-29 1948 and that I last saw h/h alive on 11-28 1948.

Immediate cause of death: Coronary Occlusion — Duration

Due to: Hypertensive Cardio-Vascular Disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Louis Vogel Jr. M. D.

Address 2611 E Hoffman St Date signed 11-29-48

65024

AB-122212

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65024

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 28yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 317 S. Baylis St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Charles Vadasky

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-89-5937

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Cecelia

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr) Aug. 15- 1892

8. AGE: Years	Months	Days	If less than one day
56	3	11	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Steel Worker

11. Industry or business Beth. Steel, Sp. Pt.

FATHER

12. Name John Vadasky (D

13. Birthplace Poland

MOTHER

14. Maiden Name Antoinette ?

15. Birthplace Poland

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-48 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location German Hill Road

18 (a) Funeral director John G. Connelly

(b) Address 418 Eastern Ave. East

19 DEC 31 1948 (Date rec'd by registrar) (b) Hunter Lee Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26- 1948, at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13- 1948 to 11-26- 1948. and that I last saw h[illegible] alive on 11-26- 1948.

Immediate cause of death Fatal coronary Pulmonary Failure - embolism — Duration 7 hrs

Due to

Due to

Other Conditions Perianal draining sinus - 4 yrs — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Frank M. Shipley M.D.

Address Balt. City Hosp. Date signed 12-28-48

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65045

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address. Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp Inc.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Fulton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 17 1861

8. AGE: Years	Months	Days	If less than one day
87	1	13	hr. min

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Lewis
13. Birthplace Maryland

MOTHER
14. Maiden Name Gertrude Walter
15. Birthplace Fulton Md.

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1948 (month) (day) (year)
(c) Cemetery or crematory Lutheran Church Cemetery
Location Fulton, Md.

18 (a) Funeral director Adkins & Talbert
(b) Address 5th Washington Blvd. Ft. Meade Md

19 NOV 30 1948 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30 1948, at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/29 1948, to 11/30 1948, and that I last saw h/m alive on 11/30 1948.

Immediate cause of death	Duration
Hypostatic Pneumonia	
Due to Arteriosclerotic Cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Joseph L. Egoute M. D.
Address Mercy Hosp Date signed 11/30/48

VS 150

T 669026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 C

Registered No. 46:826

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2401 Dumfries Court
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Dumfries Court (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah C. Bozell

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-03-4194

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Wm. Bozell Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23-1899

8. AGE: Years	Months	Days	If less than one day
49	4	5	— hr. — min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business Keirs Drug Store

FATHER
12. Name Charles Nalley
13. Birthplace Maryland.

MOTHER
14. Maiden Name ? Clemins.
15. Birthplace Maryland.

16 (a) Informant Mildred Riley
(b) Address 1928 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1st 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore - Md.

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Place

19 (a) Nov 30 1948 (Date received by Registrar) (b) Huntington Williamsport Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1948 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1948, to Nov 28 1948 and that I last saw he alive on Nov. 27 1948.

Immediate cause of death	Duration
Carcinoma of Uterus	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hazel Hall
Address 517 Scott St Date signed 11/29/48 M D

VS 150

LUNGREN

G6:027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 569

G6:027

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 313

(b) Street address Redwood & Greene

(c) Hospital or institution: Univ. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo

(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo

2. USUAL RESIDENCE OF DECEASED:

(a) State Pa. (b) County York

(c) City or town (If outside city or town limits, write RURAL and give town) York, Jacobus

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Emma Lungren

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	W	(Married)

6 (b) Name of husband or wife Wm Lungren

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1900

If less than one day

8. AGE: Years	Months	Days	hr.	min.
48 (38)	6	23		

9. Birthplace York, Penna. (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER	12. Name	Elmer Shearer
	13. Birthplace	York Co.
MOTHER	14. Maiden Name	Ellen Myers
	15. Birthplace	York Co

16 (a) Informant Kenneth C Lungren

(b) Address 655 W College Ave York, Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 1948 (month) (day) (year)

(c) Cemetery or crematory (Jacobus) Salem

Location Jacobus, Pa.

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Rd Huntington Williams, M.D.

19 (a) NOV 30 1948 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1948 at 5:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 30 1948.

and that I last saw h[illegible] alive on Nov. 29 1948

Immediate cause of death: Leptomeningitis, Ependymitis, E. Coli Infection

Duration

Due to Operative wound infection

Due to

Other Conditions Posterior fossa Meningioma, Left.

(Include pregnancy within three months of death)

Date of operation Nov. 2, 1948.

Major findings of operation: Meningioma Lt. Posterior fossa.

of autopsy:

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature David Auld M.D.

Address Univ. Hosp Date signed 11/30.

PHYSICIAN

Underline the cause to which death should be charged statistically.

8/a

AG 9028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

Registered No. AG 9028

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6014 York Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6014 York Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHRYN BLANCHE COLE

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Wesley Greer Cole

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1863

8. AGE: Years 85 Months 3 Days 12 If less than one day hr. min.

9. Birthplace Claysville, Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Litle
13. Birthplace Claysville, Pa.

MOTHER
14. Maiden Name Amanda Linville
15. Birthplace Claysville, Pa.

16 (a) Informant Dr. William E. Cole
(b) Address 6014 York Rd.

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 30 1948 (Date rec'd by registrar)
(b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28, 1948 at 3:20 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from Nov 15 1948 to Nov 28 1948, and that I last saw h alive on Nov. 28 1948

Immediate cause of death: Coronary occlusion — Duration: 6 hrs

Due to: Coronary disease myocardial disease — Duration: 3

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Stewart
Address 6 E. Read St
Date signed 11/30/48

90029

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131 B

Registered No. (66)90029

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Women's Hospital
(c) Hospital or institution: Baltimore, Md.
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 W. Saratoga (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Nina Ethel Gessert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, (married), widowed, or divorced
F	W	

6 (b) Name of husband or wife Carl E. Gessert
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1890

8. AGE: Years	Months	Days	If less than one day
58	3	17	hr. min.

9. Birthplace Chillicothe, Ohio (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Miles K. Drummond
13. Birthplace Chillicothe, Ohio

MOTHER
14. Maiden Name Effie Nichols
15. Birthplace Chillicothe, Ohio

16 (a) Informant Mr. Carl E. Gessert
(b) Address 2207 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 30 1948 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1948, at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1948 to Nov. 29 1948 and that I last saw her alive on Nov. 29 1948

Immediate cause of death	Duration
Uremia	
Due to Chronic glomerulonephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. C. Decker, M.D.
Address Women's Hospital Date signed 11-29-48 M. D.

VS 150

66:060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

66:060

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3504 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN A. CATTERTON

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-0277

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Annie M. Catterton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1893

8. AGE: Years	Months	Days	If less than one day
55	0	15	hr. min.

9. Birthplace A. A. Co., Md. (Town, county, and state)
10. Usual Occupation Warehouse Foreman
11. Industry or business American Stores Co.

FATHER
12. Name: Benjamin F. Catterton
13. Birthplace Calvert Co., Md.

MOTHER
14. Maiden Name Carrie Dalrumple
15. Birthplace Calvert Co., Md.

16 (a) Informant Mrs. Jean C. Wilson
(b) Address 2221 Piggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

NOV 30 1948

VS 152

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1948 at 7:15 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from 5/3 1945 to Nov 29 1948 and that I last saw h[illegible] alive on Nov 5 1948

Immediate cause of death: Respiratory failure — Duration: 3

Due to: Coronary occlusion

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I. Abrafkin M.D.
Address 601 N. Howard St. Date signed 11/29/48

66:031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 46:031

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2nd sign & Fairmount

(c) Hospital or institution: Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 24 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore 22

(If outside city or town limits, write RURAL and give town)

(d) Street No. 322 Druid Park Ave (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country No

3 (a) FULL NAME Mrs Nancy E Kerr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr May 7 1879

8. AGE: Years	Months	Days	If less than one day
69	6	23	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wm Jacob Wagner

13. Birthplace Penna

MOTHER 14. Maiden Name Amelia Seiler

15. Birthplace Penna

16 (a) Informant Hospital records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3- 48 (day) (year)

(c) Cemetery or crematory Pershing Hill Cemetery

Location Johnstown Pa.

18 (a) Funeral director John A. Moran

(b) Address 3000 E. Balt. St.

19 (a) NOV 30 1948 (b) Huntington Williams M.D. Registrar

(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30 1948 at 8.45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10/20 1948 to 11/30 1948 and that I last saw him alive on 11/30 1948

Immediate cause of death Cardiac failure

Due to Diabetes Mellitus

Due to Arteriosclerosis

Due to Senile Changes

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None at time

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Donald A. Hunt M.D.

Address Church Home & Hosp Date signed 12/3/48

66:30:32

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

Registered No. 66:30:32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians, please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bellona + Belvedere Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos 12 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3333 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lelia F. Frank

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife W. W. Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 8th 1875

8. AGE: Years	Months	Days	If less than one day
73	1	21	hr. min.

9. Birthplace Sharpsburg Md (Town, county, and state)

10. Usual Occupation housekeeper

11. Industry or business Home

FATHER
12. Name Nathaniel Finey
13. Birthplace Sharpsburg Md

MOTHER
14. Maiden Name Mary A. Spidleman
15. Birthplace Williamsport Md

16 (a) Informant Mrs Mary C. Watson
(b) Address 3333 N Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cem Location Hagerstown Md.

18 (a) Funeral director John J. Cowan & Son
(b) Address 22 E. 03 St Hagerstown Md

19 (a) NOV 30 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29th 1948 at 12 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 19 1948 to Nov. 29 1948, and that I last saw h alive on Nov. 28 1948.

	Duration
Immediate cause of death Uraemia	1 wk
Due to Chronic Nephritis	6 mos
Due to Chronic Myocarditis	2 yrs.
Other Conditions (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Finkelman M. D.
Address 1136 Poplar Grove Date signed 11/30/48

VS 150

66:10.533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. 66:10.533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 428 N. Hilton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 428 N. Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fulton F. Faulconer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Mary Johnson

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1882

8. AGE: Years	Months	Days	If less than one day
66	2	22	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Faulconer
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Mary Faulconer
(b) Address 428 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1/48. (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Road

18 (a) Funeral director Harry H. Nuttle
(b) Address 4101 Edmondson Ave

19 [illegible] 30 1948 (b) Huntington Williams, M.D. Registrar
(Signature to be by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28/48. 19 . at 6.55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to Nov 28 1948. and that I last saw him alive on Nov 28 1948.

	Duration
Immediate cause of death: Abdominal Metastases	1 Year
Due to: Neuronoma, site unknown	Unknown
Due to:	
Other Conditions: Arteriosclerosis, generalized	

(Include pregnancy within 3 months of death)

Date of operation April 1947

Major findings of operation: Extension of Neuronoma into Abdomen

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin L. Simpson M.D.
Address 107 St Paul St Baltimore 2 Md. Date signed 11/29/48

Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1951

Registered No. 669034

669034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State DC (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Sixth St. (If rural give location)
(e) Citizen of foreign country? DC (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS JOSEPH BENJAMIN LAMPKIN

3 (b) If veteran, name war

3 (c) Social Security Account No. 228-10-2341

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Bertie Lampkin
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1903

8. AGE: Years	Months	Days	If less than one day: hr.	min.
45	9	3		

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Oiler
11. Industry or business Seafarer

FATHER
12. Name Tommy Lampkin
13. Birthplace Va.

MOTHER
14. Maiden Name Florence ?
15. Birthplace Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3 1948 (month) (day) (year)
(c) Cemetery or crematory St. George's
Location St. George's Md. Prof.

18 (a) Funeral director W. Frank Gallagher Sons
(b) Address Leonardtown Md.

19 (a) Huntington Williams M.D. (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1948 at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 23 1948 to Nov. 29 1948, and that I last saw him alive on Nov. 29 1948.

Immediate cause of death: Hemorrhage from gastro-intestinal tract. — Duration: 1 day

Due to: Perforation of esophagus, due to foreign body.

Due to: [illegible] CERTIFICATION APPROVED

Other Conditions

Howard A. Mallis M.D.
(Include pregnancy within 3 months of death) CORONER OR ASST. MEDICAL EXAMINER

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence November 21, 1948 M
(c) Where did injury occur? 711 Sixth St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Chicken bone perforated esophagus.

23. Signature Jack L. James M. D.
Address U.S. Marine Hosp. Date signed 11-30-48

VS 180

G69035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G69035

BCH - 124313

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Glen Burnie, Maryland (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES FLEETWOOD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11/13/75

8. AGE: Years	Months	Days	If less than one day
73	-	11	hr. min

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James H. Fleetwood
13. Birthplace Delaware

MOTHER
14. Maiden Name Mary Anna Wright
15. Birthplace Delaware

16 (a) Informant B.C.H. records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/1/48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Glen Haven
Location Glenburnie Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29/48 19 at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/48 19 to 11/29/48 19 and that I last saw him alive on 11/29/48 19

Immediate cause of death	Duration
Cerebral Vascular Accident	
Due to Hypertensive Heart Disease	
Due to	
Other Conditions Auricular fibrillation	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Kushen M.D.
Address Balto City Hosp Date signed 30 Nov 48

66936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 157E

Registered No. 66936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State N. C. (b) County

(c) City or town Lincolnton (If outside city or town limits, write RURAL and give town)

(d) Street No. 303 N. Academy (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Jimmy Roland Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5-15-42

8. AGE: Years	Months	Days	If less than one day
6	6	15	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Winalum Brown

13. Birthplace N. C.

MOTHER 14. Maiden Name Isabelle Wood

15. Birthplace N. C.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)

(c) Cemetery or crematory Lincolnton

Location Lincolnton N. C.

18 (a) Funeral director Pelham Co. Inc.

(b) Address 1297 A Todd St

19 (a) [illegible] 1948 (Date rec'd by registrar) (b) Huntington W. Va. (Burial permit)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1948, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1948, to 11-30 1948, and that I last saw him alive on 11-30 1948.

Immediate cause of death: Brain abscess — Duration 3 months

Due to: Tetralogy of Fallot — life

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov. 30, 1948

Major findings of operation: Brain abscess rt. frontal region

of autopsy: Tetralogy of Fallot

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert P. Green, M. D.

Address Johns Hopkins Hosp. Date signed Nov 30/1948

X.

VS 159

6690.57

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

6690.57 Registered No. 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5913 Glen Falls Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5913 Glen Falls Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert J. Gunnte

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma Quante
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 12, 1888

8. AGE: Years	Months	Days	If less than one day
60	5	17	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Social Security Board

FATHER
12. Name William Quante
13. Birthplace Denmark

MOTHER
14. Maiden Name K. Verne Trott
15. Birthplace Alabama

16 (a) Informant Emma Quante
(b) Address 5913 Glen Falls Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 3 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul Street

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1948, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3 1946 to 11/24 1948.
and that I last saw h alive on 11/24 1948.

Immediate cause of death — Duration

Acute Cerebral Hemorrhage

Due to Chronic Nephritis

Due to Chronic Cerebral Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature A. H. Bornstein
Address 104 E. Biddle St. Date signed Nov. 30/48

VS 150

Grave #1

22621A

46038

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 1168

CERTIFICATE OF DEATH 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Found ft. of Fell St.
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Unknown (If outside city limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown White Male

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years ? 38 | Months | Days | If less than one day: hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Police Boat
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 11/26/48

(c) Cemetery or crematory
Location PUBLIC CEMETERY NOV 26 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 DEC 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1948, at 3:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy (thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or was contributing ☐ cause of death, fill in the following:
(a) Date of injury ? at ? M.
(b) Where did injury occur? Found ft. of Fell St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public
(d) Means of injury Drowned (Found)

23. Signature George [illegible] M.D.
Medical Examiner
Date signed 9-15-4

VS 151

6650.49

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

935

6650.49
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6725 Robert Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6725 Robert Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Dauts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles Dauts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19-1878

8. AGE: Years	Months	Days	If less than one day
70	6	10	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Solowska
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Frank Dauts
(b) Address 501 S. Decker Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2/48 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location German Hill Rd.

18 (a) Funeral director John C. Miller
(b) Address 2334 Jefferson St.

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Interred Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1948, at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 1946 to NOV 1948, and that I last saw h[illegible] alive on NOV 29 1948.

Immediate cause of death	Duration
CORONARY THROMBOSIS	1 M
Due to HYPERTENSIVE C.V.DIS	5 YRS.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen C. Mastonicola
Address 6714 Holabird Ave Date signed 11/30/48 M.D.

VS 150

66040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52

Registered No. 66040

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 Hillside Road
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Hillside Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Grace E. Borum

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Wm. D. L. Borum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1862

8. AGE: Years	Months	Days	If less than one day
86	--	18	hr. min.

9. Birthplace Harrisonburg, Va. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Theophilus Ott
13. Birthplace Harrisonburg, Va.

MOTHER
14. Maiden Name Mary Ott
15. Birthplace Harrisonburg, Va.

16 (a) Informant Mrs. Emma D. Griffin
(b) Address 6 Hillside Road, Baltimore 10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery ~~crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1948 at 5.30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from July 4 1948 to Nov. 30th 1948, and that I last saw her alive on Nov. 30th 1948.

Immediate cause of death	Duration
Pneumonia due to Cardiac decompensation	3 months
Due to Myocardial insufficiency	1 month
Due to Arteriosclerosis	long
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation No
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1300 N. Calvert St. Date signed

VS 150

66:061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

66:061 Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1717 BAKER St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1717 BAKER St (If rural give location)

(e) Citizen of foreign country? Yes or No

If yes, name country

3 (a) **FULL NAME** ROXANNA M. PRYOR (ROSA M PRYOR)

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1879

8. AGE: Years 69 Months 2 Days 6 If less than one day: hr. min

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name CHARLES C PRYOR

13. Birthplace Md

MOTHER 14. Maiden Name HARRIET M SWOPE

15. Birthplace md

16 (a) Informant K. PEARL JONES

(b) Address 1717 BAKER St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3-1948 (month) (day) (year)

(c) Cemetery or crematory MT Bethel Cem

Location Frederick County Md

18 (a) Funeral director Robt Or B. M. Walters

(b) Address Brady, Strickler Sts

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Registrar Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1948 at 3:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 30 1947 to Nov 29 1948. and that I last saw her alive on Nov 29 1948

Immediate cause of death

1) Hypertensive Cardio Vascular disease

Due to:

Due to

Other Conditions Senile Cardiac Failure

(Include pregnancy within 3 months of death)

Date of operation — None

Major findings of operation:

of autopsy: — Dr

Duration
2 yrs
1 day

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?

(e) Means of injury

23. Signature Earl L Chambers M.D.

Address 4108 Liberty Hts Date signed 11/30/48

VS 150

Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4609 York Road
(c) Hospital or institution: Baltimore, 12 Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 27 10
(e) Length of stay in Baltimore (yrs., mos., or days) 9 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Rising Sun, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Ollie Ruth Lindamood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Widowed

6 (b) Name of husband or wife Fredrick Lindamood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21, 1873

8. AGE: Years	Months	Days	If less than one day
75	3	9	hr. min.

9. Birthplace Wytheville, Va (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Daniel Gregory Blessing

13. Birthplace Wytheville, Va

MOTHER 14. Maiden Name Mary Louise Carter

15. Birthplace Wytheville, Va

16 (a) Informant Elsie Lindamood

(b) Address 4609 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4 1948 (month), (day) (year)

(c) Cemetery ~~or crematory~~ West Huntingham

Location Colgate Md.

18 (a) Funeral director J. E. Tyson.

(b) Address Rising Sun Md.

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Huntington & Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30 1948, at 10. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/30 1948, to 11/30 1948, and that I last saw her alive on 11/30 1948

Immediate cause of death Cerebral hemorrhage. Duration 2 hrs.

Due to Hypertension

Due to Arteriosclerosis

Other Conditions CERTIFICATION APPROVED BY

(Include pregnancy within 3 months)

Major findings

Of operations CHIEF OR ASST. MEDICAL EXAMINER

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry D. McCarty M. D.

Address 37 W. Preston Date signed 11/30/48

VS 3

66-9033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

66-9033
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1566 Richland St
(c) Hospital or institution: 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)
(d) Street No. 1566 Richland St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME William Denmark

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29-1938

8. AGE: Years 10 Months - Days - If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name William Denmark

13. Birthplace Md

MOTHER 14. Maiden Name Ester Curtis

15. Birthplace Md

16 (a) Informant William Denmark

(b) Address 1566 Richland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location West Port

18 (a) Funeral director U G Brooks

(b) Address 1463 N. Carey St

DEC 1 1948 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1948 at 2:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/29 1948 to 11/29 1948 and that I last saw h[illegible] alive on 11/29 1948

Immediate cause of death Labor Pneumonia — Duration

Due to

Due to

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Blue Rhetta

Address [illegible] Date signed 12/30 48

VS 150

30504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 30504

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3056 Stafford St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3056 Stafford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY C. MITCHELL.

3 (b) If veteran, name war: Spanish-American
3 (c) Social Security Account No. 215-01-1049.

4. Sex: Male. | 5. Color or race: White. | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Annie M. Mitchell.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5-1872

8. AGE: Years 75 | Months 11 | Days 26 | If less than one day: 24 hr. min.

9. Birthplace Baltimore-Md. (Town, county, and state)

10. Usual Occupation Retired-Interior Decorator.

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace Unknown.

MOTHER
14. Maiden Name Unknown.
15 Birthplace Unknown.

16 (a) Informant James F. Mitchell.
(b) Address 3056 Stafford St.

17 (a) Burial, (b) Date thereof Dec. 2-48. (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore-Md.

18 (a) Funeral director Charles J. Schwab
(b) Address 3512 Frederick Ave.

19 DEC 1 1948 Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1948 at 1.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1943 to Nov. 29 1948. and that I last saw h alive on Nov. 24 1948

Immediate cause of death — Duration

(a) Cerebral Thrombosis — 1 yrs.
Due to (b) Cardio-Vascular-Renal Disease — 5 yrs.
Due to (c)
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address 40 E. 23rd St. Date signed 12-4-48

466045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 46B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Woodbine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Fair (George W. Fair)

3 (b) If veteran, name war — —

3 (c) Social Security Account No. 215-03-8014

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rita Fair
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr) 2-22-06

8. AGE: Years	Months	Days	If less than one day
42	9	7	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Brakeman
11. Industry or business

FATHER
12. Name Oliver Fair
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Thompson
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSP

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Baltimore

18 (a) Funeral director Philip Dennis & Sons
(b) Address 2024 Orleans St.

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS · 50

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1948, at 11 Le P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 1948 to 11-29 1948, and that I last saw him alive on 11-29 1948.

Immediate cause of death Carcinoma of stomach & extension to liver — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Forgotten Ca of stomach & liver metastasis
of autopsy: Ca stomach liver metastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. D. Jackson
Address The Johns Hopkins Hosp Date signed 11/30/48 (M/D)

66036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

Registered No. 66036

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) less than 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) less than 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write U. S. Land or give town) WARWICK

(d) Street No. 1643 [redacted] Ave. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME STEPHEN W Richard E TALLY (TALLEY) (Stephen Richard Talley)

3 (b) If veteran, name war WW I

3 (c) Social Security Account No. 212-14-8038

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1891

8. AGE: Years 57 | Months 9 | Days 26 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Mate

11. Industry or business Seafarer

FATHER

12. Name Stephen Tally

13. Birthplace Md.

MOTHER

14. Maiden Name Mary [redacted] KAUFMANN

15. Birthplace Md.

16 (a) Informant Records

(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Dec. 3/48 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location Balto. Md.

18 (a) Funeral director Phelps Hewig Sons

(b) Address 2024 Orleans St.

19 (a) DEC [illegible] 1948 (Date rec'd by registrar) **(b)** Huntington Williams [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1948, at 3:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1948 to Nov. 30 1948, and that I last saw him alive on Nov. 30 1948.

Immediate cause of death 1-Gastroenteritis due to unknown cause

2- Syphilitic heart disease

Duration: 6 days Unknown

~~Due to~~

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John L. Wilson

John L. Wilson, Sr. Surgeon

Address Clinical Director Date signed 11/30/48

VS 180

66047 ✓ 66047

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 55E

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4330 Parkside Drive.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4330 Parkside Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara M. Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 29, 1878

8. AGE: Years	Months	Days	If less than one day
70	8	—	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Rudolph Recktenwald
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna Klemm
15. Birthplace Baltimore

16 (a) Informant Herman Hughes
(b) Address 4330 Parkside Drive.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

DEC 1 19 (a) 1948 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1948, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1948, to Nov. 29 1948, and that I last saw her alive on Nov. 29 1948.

Immediate cause of death — Duration
Carcinomatosis
Due to Etiology unknown.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature H. B. Lewis, M.D.
Address 3400 Eastern Ave Date signed 11/30/48

VS 150

G6038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12-1a

G6038
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5440 Belair Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5416 Gerland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice T. Phebus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1888

8. AGE: Years	Months	Days	If less than one day: hr.	min.
60	6	1		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name Hugh Cox.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rose McClend
15. Birthplace Baltimore

16 (a) Informant George T. Phebus
(b) Address 5416 Gerland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) [illegible] 1948 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1948 at 11:47 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24/48 to 11/28 1948 and that I last saw her alive on 11/28 1948

Immediate cause of death	Duration
Chronic myocarditis	15 yrs
Due to Cardio-vascular renal disease	
Due to Hypertension (malignant)	
Other Conditions Anemia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature J. W. Harold M.D.
4206 Harford Road Date signed 11/29/48

VS 150

66049

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Frederick Ave
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4506 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY CATHARINE WINDER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Lr. J. K. Winder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years	Months	Days	If less than one day
About 92	-	-	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER / FATHER
12. Name Benjamin F. Kershner
13. Birthplace Maryland
14. Maiden Name Margaret Costello
15. Birthplace Maryland

16 (a) Informant Miss Margaret Heaphy
(b) Address 306 Hopkins Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.
18 (a) Funeral director H. H. Ulmers and Son
(b) Address 805 N. Calvert St.

DEC 1 1948 (Date received by registrar) (b) Huntington, Indiana (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Nov 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to 30 Nov 1948 and that I last saw her alive on 30 Nov 1948.

Immediate cause of death: A.S.C.V.D.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration
.
.
.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Royer
Address 17 Wentworth Pl. Date signed 12/1/48

VS 150

66050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. 66050

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 110 N. Calhoun

(c) Hospital or institution: Franklin Sq Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hr.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balt. (If outside city or town limits, write RURAL and give town)

(d) Street No. 507 Myrtle Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Carrie Carroll

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	?

6 (b) Name of husband or wife –

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr May 27 1914

8. AGE: Years	Months	Days	If less than one day
34	6	–	hr min.

9. Birthplace Balt Md (Town, county, state)

10. Usual Occupation Domestic

11. Industry or business

FATHER	12. Name Alexander Carroll
	13. Birthplace Howard Co, Md
MOTHER	14. Maiden Name Sarah Thorton
	15. Birthplace Md

16 (a) Informant ~~Blood~~ Blanche Matthews

(b) Address 1209 Smithson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1. 1948 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery Cem.

Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley ave

19 (a) DEC 1 1948 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1948, at 8:55 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1948, to Nov 27 1948, and that I last saw h er alive on Nov 27 1948

Immediate cause of death: cardiac decompensation — Duration

Due to: Rheumatic heart disease — 10 yr

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. J. Laham M. D.

Address Franklin Sq Hosp Date signed 11-27-48

VS 150

69051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

68:001

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered, and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1047 Brantly Ave

(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 73 Yrs.,

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town) 1047 Brantly Ave

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Eugene Calhoun

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-5950A

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 10 1875

8. AGE: Years 73 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Mesmenger

11. Industry or business

FATHER 12. Name John Calhoun

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Isabella Johnson

15. Birthplace Baltimore Md

16 (a) Informant Fsnnie Smith C.

(b) Address 1047 Brantly Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4 1948 (month) (day) (year)

(c) Cemetery or crematory Mt. Arburn Cem.

Location Baltimore Md

18 (a) Funeral director Elroy C Wilson

(b) Address 1000 Brantly Ave.

19 (a) (Delivered by registrar) (b) Huntington Williams, M.D. Registrar

11-30-48 **MEDICAL CERTIFICATION**

20. DATE OF DEATH 11-30- 1948 at 4.15 pM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6 1948 to 11/30 1948. and that I last saw him alive on 11-30-1948

Immediate cause of death

Cardio-Vascular Renal Disease — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. H. Jackson

Address 1000 Arlington Ave Date signed 11/30/48

VS 150

66502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

Registered No. 66502

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Madison Avenue
(c) Hospital or institution: Bar-Wil-Ba Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1034 Leadenhall (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Watts.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov-12-1870

8. AGE: Years 78 | Months - | Days 18 | If less than one day hr. min.

9. Birthplace Calvert Co. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. E. Williams
(b) Address 1317 Madison Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Brooklyn, Md.

18 (a) Funeral director Joseph A. Turley
(b) Address 640 W. Barre St.

19 (a) DEC 1 1948 (Date rec'd by registrar) (b) Funeral Director, Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30th 1948, at 2 A; M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28-1948 to 11-30-1948, and that I last saw her alive on November 29 1948

Immediate cause of death: Cancreme both Legs. Arterio sclerotic. — Duration: 1 year
Due to Cardio-Renal disease.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address 900 N. Arlington Ave Date signed 11-30-48

VS 150

48-50-53

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 106c

PLEASE WRITE PLAINLY, with unfading ink. Every item of information must be entered. Supply correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 253 N. Bruce St.
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 253 N Bruce Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Preston Baynor

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1948 M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 29 1948 Nov. 29 1948 and that I last saw h[illegible] alive on Nov 29 1948

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23 1945

8. AGE: Years	Months	Days	If less than one day
3	8	6	hr. min

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name James G. Baynor

13. Birthplace Baltimore Maryland

MOTHER 14. Maiden Name Mary Holley

15. Birthplace Baltimore Maryland

16 (a) Informant James G. Baynor

(b) Address 253 N Bruce Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3, 1948 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn Cemetery

Location Baltimore Md

18 (a) Funeral director Joseph A. Lively

(b) Address 66 West Baltimore Street

19 DEC 1 1948 (b) [illegible] Washington Williamsport Md

(Date rec'd by registrar) (Registrar)

Immediate cause of death	Duration
Respiratory failure	
Due to Laryngotracheobronchitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. C. Hunter, M.D.

Address Univ. Hosp. Date signed 11 29 48

VS 15)

16-50-A 292317

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 45F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk - (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 269 L. Route 3 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Collingsworth
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-11-91

8. AGE: Years	Months	Days	If less than one day
57	8	14	hr min.

9. Birthplace Ky. (Town, county, and state)
10. Usual Occupation Hostler
11. Industry or business Bethlehem Steel

FATHER
12. Name George Collingsworth
13. Birthplace Ky.

MOTHER
14. Maiden Name Louisa McDaniel
15. Birthplace Ky.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd Location Rogers Ave. Ellicott City, Md

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

19 (a) DEC 1 1948 (b) Huntingdon Indiana, Ind. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Nov. 25, 1948 at 1 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 8 1948 to Nov. 25 1948 and that I last saw him alive on Nov. 25 1948

Immediate cause of death	Duration
Pneumonia	
Due to Infiltration by carcinoma of nasopharynx into Brain	
Due to Metastasis, Thorax	
Other Conditions Intestinal Obst.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature George A. Caldwell M D
Address Johns Hopkins Hospital Date signed 12-2-48

-2

6690:5

Exhibit # 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. 6690:5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State U N (b) County
(c) City or town (If outside city or town limits, write RURAL and give town) X N
(d) Street No. (If rural give location) N
(e) Citizen of foreign country? (Yes or No) U N W N
If yes, name country

3 (a) FULL NAME Unknown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years: 55 | Months | Days | If less than one day: hr min

9. Birthplace U N (Town, county, and state)

10. Usual Occupation U

11. Industry or business W N

FATHER
12. Name U
13. Birthplace N

MOTHER
14. Maiden Name N
15. Birthplace U

16 (a) Informant W N
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 12/26/47 (mo., day, yr.)
(c) Cemetery or crematory
Location PUBLIC CEMETERY NOV 26 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 DEC 1 1948 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948 at 7.40 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intracranial hemorrhage (subdural)

Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Aug. 7 at ? M.
(b) Where did injury occur? Found 701 Fleet St.
(c) Did injury occur at home, on farm, industrial place, or public place? Public (Specify)
(d) Means of injury? Unknown

23. Signature George G. Merrill M.D.
Medical Examiner
Date signed 8/25/48

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

Registered No. (illegible)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 East Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK J. ANDERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1901

8. AGE: Years	Months	Days	If less than one day: hr.	min.
47	4	8		

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER
12. Name Benjamin Franklin Anderson
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary MacNerny
15. Birthplace Washington D.C.

16 (a) Informant Stella Berger
(b) Address 809 N Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2-1948 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Geo McGinnis Son
(b) Address 811 N Wolfe St

19 DEC 1 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 12

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1948, at 11.10 P.M.

21. I certify that I took charge of the remains described above, held an Inquir & Inspec. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Shock

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-29-48 at approx. 11.00 A.M.
(b) Where did injury occur? Baltimore City Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? hospital While at work? no
(d) Means of injury Jumped from high place

23. Signature Emil L Rey M.D.
Medical Examiner mp

Date signed November 30, 1948

66905?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

66405?

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK.—Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 260 N. Bruce St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 - 2

(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)

(d) Street No. 260 N. Bruce St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Matilda Williams.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race C

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 1873

8. AGE: Years 75 Months 5 Days 20 If less than one day hr. min.

9. Birthplace Howard County, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Alexander Williams

13. Birthplace Howard Co., Md.

MOTHER 14. Maiden Name Rosella Benson

15. Birthplace Howard Co Md.

16 (a) Informant Genevieve Jones.

(b) Address 260 Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2, 1948 (month) (day) (year)

(c) Cemetery or crematory Western Star.

Location Catonsville, Md.

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) DEC 1 1948 (Date received by registrar) Huntington Williams, Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1948, at 6 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 1948, to 11/29 1948, and that I last saw h[illegible] alive on 11/23 1948

Immediate cause of death Myocardial Failure

Due to Hypertensive Cardiovascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Preston Grant M.D.

Address 60 W. Conway St Date signed 11/30/48

G69058

JL - 124776

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 8

46 P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town altimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Vincent St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Matthew Crowner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 13, 1881

8. AGE: Years	Months	Days	If less than one day
67 yrs.	4	14	hr min

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jim Crowner (D
13. Birthplace ?

MOTHER
14. Maiden Name Sarah Cooper (D
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1, 1948 (month) (day) (year)
(c) Cemetery or crematory Western Star.
Location Catonsville Md.

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) DEC 1948 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1948 at 2.45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 22 1948 to Nov. 27 1948. and that I last saw him alive on Nov. 27 1948

	Duration
Immediate cause of death Bronchopneumonia	2 days
Due to Carcinoma of the Stomach	6 mo.
Due to	
Other Conditions Dongrene of right foot	2-3 wks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. S Stutzmann M. D.
Address Balto. City Hosp. Date signed 11-28-48

VS 150

66906:9 ✓ 66906:9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1214

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 760 W. Saratoga St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 670 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Butler.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Alexander Butler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 1894

8. AGE: Years 57 | Months - | Days | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Md.

16 (a) Informant Alexander Butler
(b) Address 670 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2, 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Burlington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26/48 19 , at 11:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-2-48 19 to 11-26-48 19 and that I last saw h[illegible] alive on 11-23-48 19

Immediate cause of death: Coronary Thrombosis

Due to Nephritis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: uncertain / unknown / unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen E. Loman M.D.
Address 10 E. Eden St. Date signed 12-3-48

PLEASE WRITE PLAINLY, WITH LEAD PENCIL OR PEN AND INK. Every item of information should be answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66960 BALTIMORE CITY HEALTH DEPARTMENT 66960
Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 658 W. Franklin St.
(c) Hospital or institution:
University Hoapital 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 658 W. Franklin St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry ~~Harry~~ McCobbin McCobbin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Theresa McCobbin

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) July 4, 1884

8. AGE: Years: 64 yrs. Months: 4 Days: 23 If less than one day: hr. min

9. Birthplace: Harpers Ferry, West Virginia
(Town, county, and state)

10. Usual Occupation: Baggage man

11. Industry or business: B & O, Camden Station

FATHER
12. Name: Benton McCobbin
13. Birthplace: Harpers Ferry, West Virginia

MOTHER
14. Maiden Name: Bettie ?
15. Birthplace: Harpers Ferry, West Virginia

16 (a) Informant: Theresa McCobbin
(b) Address: 658 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: December 1, 1948 (month) (day) (year)

(c) Cemetery or crematory: Mount ~~Albon~~ Auburn cem

Location:

18 (a) Funeral director: Katie Williams

(b) Address: 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) (Signature)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1948 at 11:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royston M.D.
Medical Examiner
Date signed 12-2-48

DEC 1 1948

VS 15!

G69061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G69061

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3609 Menlo Drive.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 Yrs. 20

(e) Length of stay in Baltimore (yrs., mos., or days) 27 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3609 Menlo Drive. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME AARON ROTHSCHILD.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of ~~husband or~~ wife Addye B. Rothschild. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1859.

8. AGE: Years	Months	Days	If less than one day hr.	min.
89	9	28		

9. Birthplace Germany. (Town, county, and state)

10. Usual Occupation Retired Bookkeeper.

11. Industry or business

FATHER

12. Name Zadok Rothschild,

13. Birthplace Germany.

MOTHER

14. Maiden Name Violet Nusbaum,

15. Birthplace Germany.

16 (a) Informant Mrs. Addye B. Rothschild,

(b) Address 3609 Menlo Drive.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48. (month) (day) (year)

(c) Cemetery ~~or crematory~~ Hebrew Friendship

Location Balto. Md.

18 (a) Funeral director Burial Somewhere Not

(b) Address 1902 Eutaw Place.

19 (a) 1948 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30th. 1948 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1948 to November 1948. and that I last saw h l M alive on 29 Nov. 1948

Immediate cause of death Bronchopneumonia

Due to Arteriosclerosis, Generalized

Duration Weeks

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Chas. L. Hamburger Jr. M. D.

Address 1207 Eutaw Place Date signed

VS 150

G69062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

G69062
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3618 Glen Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3618 Glen Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Henry Clarence Kell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	W.

6 (b) Name of husband or wife Helen Agnes (Nellie)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1875

8. AGE: Years	Months	Days	If less than one day: hr.	min
73	2	19		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Broker.
11. Industry or business

FATHER
12. Name Peter Kell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Honorah Sullivan
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Alice Fairbank
(b) Address 3618 Glen Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-48 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Lazarus Byers
(b) Address 5005 Park Heights Ave

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar
DEC 1 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1948, at 2:18 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from June 1948, to Nov. 1948, and that I last saw him alive on Nov 29 1948.

Immediate cause of death	Duration
Carcinoma of sigmoid colon	4-5 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation April 1947
Major findings of operation: Inoperable carcinoma of sigmoid colon
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert H. Gundersheimer, Jr. M.D.
Address Riviera Apts. Lake Dr. Date signed Nov. 29, 1948

X

Please write plainly with pen or pencil. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Give correct age is especially important.

G6:90:63

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G6:90:63
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2939 Presbury St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2939 Presbury St (If rural give location)
(e) Citizen of foreign country? Yes or No) If yes, name country

3 (a) FULL NAME Gladys Carroll Keeney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Arthur D. Keeney 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov 24, 1907

8. AGE: Years	Months	Days	If less than one day
41	-	5	hr. min.

9. Birthplace Harford Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Carroll Brown
13. Birthplace Chesterlown, Maryland

MOTHER
14. Maiden Name Marion Hartline
15. Birthplace Maryland.

16 (a) Informant Mrs Arthur D Keeney
(b) Address 2939 Presbury St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Forest Park Md

18 (a) Funeral director Edward Engel
(b) Address 5225 Reisterstown Rd

19 (a) (b)
(Date rec'd by registrar) Registrar

Kentucky for Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1/48 19 at 8 03 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 19 48 to 12/1/48 19
and that I last saw h alive on 11/1/48 19

Immediate cause of death Pulmonary Embolism
From Pneumonia
of Cold

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify in public place)
(e) Means of injury

23. Signature [illegible]
Address 3033 W North Ave Date signed 12/1/48 M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be sure to give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~Hooked Crosses~~ ~~Case~~ BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66504

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered, and the information should be correct as is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Broadway & Fairmount

(c) Hospital or institution: Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 426 Murdock Rd

(Rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Angelina T. McClintock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Frederick T. McClintock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 27 1881

8. AGE: Years	Months	Days	If less than one day
67	9	2	hr. min.

9. Birthplace Maine (Town, county, and state)

10. Usual Occupation Nurse Wife

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace

MOTHER

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mr. Paul R. Younts

(b) Address 426 Murdock Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/1/48 (month) (day) (year)

(c) Cemetery or crematory Ebenezer Cem.

Location Charlotte, N. C.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 157

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29/48 19 5:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/18/48 to 11/29/48 19 48 and that I last saw him alive on 11/29/48.

Immediate cause of death Cerebral Thrombosis

Due to Hypertension

Due to Acute CVA

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Clinical

Duration

PHYSICIAN

(Underline the cause to which death should be charged statistically.)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Donald W. Mintz M. D.

Address Church Home & Hosp. Date signed 11/30/48

66805

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

66805 Registered No.

74a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3302 Powhatan Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3302 Powhatan Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH E. LEWIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Bertha C. Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 9, 1875

8. AGE: Years	Months	Days	If less than one day
73	9	21	hr. min.

9. Birthplace Centerville, Mass. (Town, county, and state)
10. Usual Occupation Pres.
11. Industry or business Jos. E. Lewis & Co., Inc.

FATHER
12. Name Joseph Freeman Lewis
13. Birthplace Mass.

MOTHER
14. Maiden Name Emma Hinckley
15. Birthplace Mass.

16 (a) Informant Mr. William W. Saunders
(b) Address 203 Goodale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date rec'd by Registrar (b) Registrar

DEC 1 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30, 1948, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 1-1-1940 to 11-30-1948 and that I last saw alive on 11-30-1948

Immediate cause of death

Duration

Myelogenous Leukemia — 2 yr.

Due to

Due to Arterial Sclerotic Cardiac disease — 5 —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard Fisher Lewis M.D.
Address 2604 Garrison Blvd Date signed 12-1-48

G6S0r.6

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

Registered No. G6S0r.6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be currently supplied. Its correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave.
(c) Hospital or institution:
Home for Aged of M.E. Church
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUSIE M. FULLER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: William F. Fuller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1863

8. AGE: Years 85 | Months 10 | Days 29 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation -

11. Industry or business

FATHER
12. Name James E. Johnson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Wherrett
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Miriam C. Coates, Supt.
(b) Address 2211 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b). Address Balto., Md.

19 (a) Filed [illegible] (b) [illegible] Registrar

VS 50

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30, [illegible] at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 19 48 to Nov 29 19 48
and that I last saw her alive on Nov 29 19 48

Immediate cause of death: Myocardial insufficiency — Duration: 1wk
Due to: Arteriosclerosis — 10 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause (A, B, C or D) which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur J. Dimes M. D.
Address 2004 Eutaw Pl. Date signed 11 30 48

66807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 2025 Ellsworth St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John W. Woodruch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/23/1893

8. AGE: Years	Months	Days	If less than one day
55	3	10	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Moulder

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Sadie Slacum
(b) Address 3215 Shannon Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern Ave Ex. Balto. Md.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto. Md.

19 (a) 1 1948 (Date rec'd by registrar) (b) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Nov. 1948 at 9.50P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Vascular Accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D. Medical Examiner
Date signed 30 Nov. 48

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66-90-8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

66-90-8

Registered No. .....

Hospital Disposal

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution:

JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Essex

(If outside city or town limits, write RURAL and give town)

(d) Street No. 13 Marus Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Short Twin A

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/6/48

8. AGE: Years | Months | Days | If less than one day: hr. min

Years	Months	Days	If less than one day
		1	hr. min

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Joseph Short

13. Birthplace Md

MOTHER

14. Maiden Name Doreen Buckley

15. Birthplace England

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ..... (b) Date thereof

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location .....

18 (a) Funeral director

(b) Address .....

19 (a) 1948 (b) Huntington Williams, M.D.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1948 at 12 M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/5/48 to 11/6/48 and that I last saw he alive on 11/6/48

Immediate cause of death

Asphyxia neonatorum

Due to Prematurity

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

Autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature A. C. Young M. D.

Address Johns Hopkins Hosp Date signed 11-6-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VE 150

over

Hospital Disposal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G6904

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore Co

(c) City or town Essex (If outside city or town limits, write RURAL and give town)

(d) Street No. 13 Marie Ave (If rural give location)

(e) Citizen of foreign country? no (Yes or No). If yes, name country

3 (a) FULL NAME Baby "Boy B" Short

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased mo., day, yr 11-6-48

8. AGE: Years | Months | Days | 12. If less than one day: 1 hr. 36 min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Short

FATHER 13. Birthplace Md

MOTHER 14. Maiden Name Doree P. Buckley

MOTHER 15. Birthplace England

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) 1948 (Date rec'd by registrar) (b) Carlton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7-1948 at 10:10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-6 1948 to 11-7 1948, and that I last saw him alive on 11-7 1948

Immediate cause of death: Atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. C. Hamy M. D.

Address Johns Hopkins Hosp Date signed 11-5-48

VS 150

6540.0

Square #3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

6[illegible].0

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered, as the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(b) City or town (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 55 | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 11/30/48

(c) Cemetery or crematory
Location PUBLIC CEMETERY NOV 30 1948
Commissioner of Health

18 (a) Funeral director
(b) Address

19 DEC 1 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1948 at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy (Inspection or Inquiry) fold that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial Degeneration
Fatty degeneration of liver, chronic alcoholism.
Due to

Other Conditions
(Include pregnancy within three months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (Specify)
(d) Means of injury.

23. Signature Emil L. Rose M.D.
Medical Examiner
Date signed 8-31-48

VS 151

66071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

66071 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3047 Abell Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3047 Abell Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNA ADELE FRIEDEL

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife: --
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr): May 9, 1900
8. AGE: Years: 48 Months: 6 Days: 20 If less than one day: hr. min
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Bookkeeper
11. Industry or business:

FATHER
12. Name: John C. Friedel
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Katharine Schisler
15. Birthplace: Sweet Aire, Balto. Co., Md.

16 (a) Informant: Mrs. Clara F. Brown
(b) Address: 2703 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKLER & SONS
(b) Address: Baltimore, Md.

19 (a) DEC 1 1948 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1948 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1948 to Nov. 29 1948 and that I last saw [illegible] alive on Nov. 29 1948

Immediate cause of death: Coronary thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: [illegible]
Address [illegible] Date signed 11/30/48

G6:072 ✓ G6:072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 R

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4806 Laurel Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4806 Laurel Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FRANCES LEE HEARN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Wm. J. Hearn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1866

8. AGE: Years	Months	Days	If less than one day
82	0	13	hr. min.

9. Birthplace Del. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name David Hudson

13. Birthplace Del.

MOTHER

14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Mrs. Ola H. Gaither

(b) Address 4806 Laurel Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) Date rec'd by registrar DEC 1948 (b) Registrar

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1948 at 7:00a. M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 27 1947 to Nov 29 1948 and that I last saw h alive on Nov 29 1948.

Immediate cause of death

Mitral Insufficiency

Due to Cardiac Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

1/27/47

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Mrs O H Gaither

Address 4803 Park Heights Av Date signed 11/30/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information, should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 6[illegible]0.73

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore - 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Chestnut Hill Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL MORAN - also known as MICHAEL GATTO

3 (b) If veteran, name war WW I

3 (c) Social Security Account No. 214-01-1185

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen Miles Moran

6 (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) June 22, 1901

8. AGE: Years 47 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Hairdresser

11. Industry or business Hutzler Bros.

FATHER
12. Name Giuseppe Gatto
13. Birthplace Italy? Pa.

MOTHER
14. Maiden Name Rosalie ? Sanskey
15. Birthplace Italy

16 (a) Informant Mrs. Helen I. Moran - wife
(b) Address 521 Chestnut Hill Ave. -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2. 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Baltimore Md.

18 (a) Funeral director MEANEY SANDER & SONS. INC.
(b) Address Baltimore Md.

19 (a) [illegible] (Date rec'd by Registrar) (b) Huntington Williamsport

DEC - 6

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 19 48 at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 19 48 to Nov. 29 19 48, and that I last saw him alive on Nov. 29 19 48.

Immediate cause of death: Coronary insufficiency — Duration: unk

Due to: Arteriosclerotic heart disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ray Howard, D
Address U.S. Marine Hosp Date signed 11/29/48

VS 150

669074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

669074 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline

(c) Hospital or Institution: St. Joseph's

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1739 Cliftview Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie Lee Bogy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife Charles F.

6 (c) If alive, give age years

7. Birth date or deceased (mo., day, yr) January 1[illegible] 1864

8. AGE: Years	Months	Days	If less than one day: hr.	min.
84	10	10		

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER	12. Name	Not Known
	13. Birthplace	" "
MOTHER	14. Maiden Name	" "
	15. Birthplace	" "

16 (a) Informant Mrs. Lottie Sturgeon

(b) Address 1739 Cliftview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/48 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Harford Rd.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 Broadway.

DEC 1 1948 (Date rec'd by registrar) Clarington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH November 28, 1948 at 4:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13, 1948 to Nov. 28, 1948, and that I last saw her alive on Nov. 28, 1948.

	Duration
Immediate cause of death - Cardio-respiratory failure	
Due to Hypostatic Pneumonia	
Due to Fractured femur - Left.	
Other Conditions Arteriosclerosis	

(Include pregnancy within three months of death)

CERTIFICATION APPROVED

Date of operation

Major findings of operation:

Thomas J. Mullis, M.D.

for: Wm. G. Helfrich, M.D.

of autopsy: CHIEF OR ASST. MEDICAL EXAMINER

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 8/5

(a) Accident, suicide, or homicide accident

(b) Date of occurrence Nov. 6, 1948 at ? M

(c) Where did injury occur? 1739 Cliftview Ave. Balto. (City or town) (County) (State)

(d) Did injury occur: about home, on farm, industrial place, in public place? home (While at work) no

(e) Means of injury slipped and fell to floor

23. Signature [illegible] St. Joseph Hospital Date signed 11/30/48

Address

For Coroner Byrnes

66:075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66:075

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Baltimore Rural (If outside city or town limits, write RURAL and give town)
(d) Street No. Belair (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leroy N. Blackwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~.
Male	White	Married

6 (b) Name of husband or wife Caroline V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 3rd 1864

8. AGE: Years	Months	Days	If less than one day
84	9	27/28	hr. min.

9. Birthplace Virginia (city, county, and state)

10. Usual Occupation Farmer

11. Industry or business Self

FATHER
12. Name Wm Blackwell
13. Birthplace Va.

MOTHER
14. Maiden Name Julia Nutt
15. Birthplace Va.

16 (a) Informant Leroy N. Blackwell Jr
(b) Address 1530 Bolton St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12-2-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Georgetown
Location Va

18 (a) Funeral director William Cook Inc.
(b) Address 1317 St. Paul St

19 (a) DEC 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1 1948, at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1948, to 12/1 1948, and that I last saw him alive on 11/30 1948.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles J. Blazek M.D.
Address Date signed 12/1/48

VS 150

669076 Neale ✓ 669076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secour 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Paddington Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

3 (a) FULL NAME Mrs. Harriet E. Neale

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Married

6 (b) Name of husband ~~or wife~~ Leonard E. Neale Jr.
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) Jan 28 1898

8. AGE: Years	Months	Days	If less than one day: hr.	min.
50	10	3		

9. Birthplace Frederick Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Howard L Smith
13. Birthplace Frederick Co Md

MOTHER
14. Maiden Name Leona Thomas
15. Birthplace Frederick Co Md

16 (a) Informant Mrs. J Duncan Watson
(b) Address 224 Laurens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3 1948 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md

18 (a) Funeral director Henry W. Kenyon & Sons
(b) Address 492 York Rd.

19 (a) (Registrar's signature) Huntington Williams (Undertaker)
DEC 2 1948

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 · 1 · 1948, at 2 45p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 · 9 1948, to 12 · 1 1948, and that I last saw her alive on 12 · 1 1948.

Immediate cause of death	Duration
Respiratory failure	
Due to Left sided Brain tumor	6 months
Due to	
Other Conditions Rt sided Hemiplegia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature McCallagham M. D.
Address Bon Secour Hospital Date signed 12-1-48

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66:07

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 66:07

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2714 Lesterstown Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2714 Lesterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Michael Woolfe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 80 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: retired

11. Industry or business

FATHER
12. Name: Samuel
13. Birthplace: Russia

MOTHER
14. Maiden Name: Esther
15. Birthplace: Russia

16 (a) Informant: Dr. Samuel B Woolfe
(b) Address: 2714 Lesterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-48 (month) (day) (year)
(c) Cemetery or crematory: Beth Isaac
Location: No Point & Germania Hill Rd

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2106 Eutaw Place Huntington Williams, Ma

19 DEC 2 - 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1- 1948 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to 12-1- 1948.
and that I last saw him alive on 11-30- 1948

Immediate cause of death: Arteriosclerotic Cardiovascular Disease — Duration: Several years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. A. Sussman M. D.
Address 1107 N. Calvert St Date signed 12-2-48

VS 50

669078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

669078 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2483 Shirley Ave

(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2483 Shirley Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sarah Kapides

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Kolman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 67 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Morris

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name Anna

MOTHER 15. Birthplace Russia

16 (a) Informant Raymond Kapides

16 (b) Address 2483 Shirley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-48 (month) (day) (year)

17 (c) Cemetery or crematory Sherrt Hesh

Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc

18 (b) Address 2100 Eutaw Place

19 DEC 2 - 1948 (Date received by registrar) Huntington Williams Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1/48 at 1:52 P M

21. I certify that death occurred on the date above stated, that I attended deceased from: (a) 1941 to (b) 12/1/48 and that I last saw h alive on 12/1/48

Immediate cause of death: Coronary astriosclerosis — Duration: 7 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Raymond Kapides

Address 2320 Eutaw Pl Date signed 12/1/48

VS 150

66907 ✓ 66907

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 Stonewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Stonewood Ave (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Charles J. Gordon

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 213-09-4527

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Katherine J. Donnelly
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr) March 4, 1899

8. AGE: Years	Months	Days	If less than one day
49	8	26	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business City Employ

FATHER
12. Name John L. Gordon
13. Birthplace Baltimore

MOTHER
14. Maiden Name Theresa Milski
15. Birthplace Baltimore

16 (a) Informant Mrs. Katherine Gordon
(b) Address 1307 Stonewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 3, 1948 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore

18 (a) Funeral director Rita Wendfeld
(b) Address 900 East Biddle St.

19 (a) DEC 2 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30, 1948 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1948 to Nov. 30 1948 and that I last saw h[illegible] alive on Nov. 29 1948.

Immediate cause of death	Duration
Coronary Thrombosis	2 hrs
Due to Angina Pectoris	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature H. J. Granger M.D.
Address 402 E. Lanvale Date signed 12/1/48

VS 155

66:060

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

116

66:456

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave.
(c) Hospital or institution: Maryland General Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Division St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Ware

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Cd	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-6-1900

8. AGE: Years 48 | Months 1 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Robert Ware Sr

13. Birthplace

MOTHER 14. Maiden Name Ellas Scott

15. Birthplace

16 (a) Informant Mrs Ellas Ware

(b) Address 1118 Division St

17 (a) Burial (b) Date thereof 12-4-48
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Baltimore Md.

18 (a) Funeral director Mrs Francis A. Humphrey

(b) Address 518 W. Biddle St.

19 (a) DEC 2 - 1948 (b) Interment or Cremation, Md.
(Date rec'd by registrar) Registrar

6

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1948, at 8:27 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Nov. 1948, to 30 Nov 1948, and that I last saw him alive on 30 Nov 1948.

Immediate cause of death	Duration
Mediastinitis	
Due to Perforation of esophagus	
Due to Possible chr. ulcer of esophagus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 29 Nov. 48

Major findings of operation: No obv. pathology

of autopsy: Rupture of esophagus

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M.T. McGowan M.D.

Address Md. Gen. Hospital Date signed 1 Dec 1948

VS 180

69061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. 60[illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 647 W. Mulberry St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Gray
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-12-12

8. AGE: Years 36 Months 8 Days 18 If less than one day: hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Arthur Briggs
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Gray
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-48 (month, day, year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mc Francis A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) [illegible] (To be filled in by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 48, at 7 3/4 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11-26 48 to 11-30 48, and that I last saw her alive on 11-30 48

	Duration
Immediate cause of death Uremia	
Congestive failure	2 mos.
Due to Hypertensive Cardio Vascular disease	5 yrs
Due to	
Other Conditions Nephro Sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

PHYSICIAN
Underline the cause for which each should be charged, state-

of autopsy: Hypertensive Cardio Renal Disease

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City, town, county, state)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard S Ross, M.D.
Address The Johns Hopkins Hosp. Balto 5 Date signed 12/1/48

VS 150

COURISEY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 60390 (2) 660832

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry (item of information should be complete) of correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution:
Dock & Samaton Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Dover
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jas P. Courisey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	C.	Widower

6 (b) Name of husband or wife Edwin Deander

6 (c) If alive, give age 5. years

7. Birth date of deceased (mo., day, yr.) July 2, 1893.

8. ACE: Years	Months	Days	If less than one day
55	4	29	hr. m.n.

9. Birthplace Cambridge, Md
(Town, county, and state)

10. Usual Occupation Steredor

11. Industry or business

FATHER
12. Name Louis Courisey
13. Birthplace Cambridge, Md

MOTHER
14. Maiden Name Emma Graham
15. Birthplace Md

16 (a) Informant Claudia M. Simpson
(b) Address 713 Pearson ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Joseph L. Wilkins
(b) Address 1207 N. Central Ave

19 (a) [illegible] (Signature of registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4/48 (Month) (day) (year) 10:20 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 12/3/48 to 12/4/48 and that I last saw h[illegible] alive on 11/30/48

Immediate cause of death	Duration
Carcinoma	[illegible]
Due to White -	
Due to [illegible]	
Other Conditions	

(Morbid conditions, if any, giving rise to the above cause, stating the underlying cause last)

Date of operation 11

Major findings of operation:

of autopsy:

PHYSICIAN
I attended the deceased from [illegible] to the date of death stated above. I last saw deceased alive on [illegible]. The cause of death was as stated above.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos A. Hooper M.D.
Address 10 N. Division Date signed 12-5-48

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. (illegible)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 N. Wolfe Street
(c) Hospital or institution:

6-44

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore
(If outside the town limits, write RURAL and give town)
(d) Street No. 413 N. Wolfe Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAMIE BROOKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-9-1880

8. AGE: Years: 68 | Months: 2 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: Euey Gross
13. Birthplace: Maryland.

MOTHER
14. Maiden Name: Priscilla ?
15. Birthplace: Maryland

16 (a) Informant: Louis Brooks
(b) Address: 413 N. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-4-48 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: A. A. County, Md.

18 (a) Funeral director: Joseph L. Locke, Jr.
(b) Address: 2044 N. Central Ave

19 (a) DEC 2 - 1948 (Date rec'd by registrar) (b) (illegible)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1948 10:10 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry had that said deceased came to her death on the day stated above, and death, in my opinion resulted from natural causes X, accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Hypertensive Cardiovascular

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributory [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature (illegible) M.D.
Medical Examiner
Date signed 11/30/48

VS 151

Please write plainly, with pen and ink. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

26083 Dec 2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 121a

Registered No. 66:054

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be accurately supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 692 Washington Blvd (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Greece

3 (a) FULL NAME Peter Plane
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2-18-79

8. AGE: Years 69 | Months 9 | Days 2 | If less than one day: hr min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Billy Plane
13. Birthplace Greece

MOTHER
14. Maiden Name Georgia ?
15. Birthplace Greece

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-48 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Windsor Mill Rd

18 (a) Funeral director Lamond Inc.
(b) Address 438-40 E. North ave

19 DEC 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30 1948 at 6 12 a M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-1 1948 to 11-30 1948, and that I last saw h[illegible] alive on 11-30 1948

Immediate cause of death: Renal Insufficiency — Duration

Due to Bilateral nephrolithiasis

Due to

Other Conditions

(Include pregnancy within 3 mo. of death)

Date of operation 11-22-48

Major findings of operation: nephrolithiasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. A. Kelly M.D.
Address Johns Hopkins Hosp Date signed 11-30-48 M.D.

VS 150

G680685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G680685

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 342 Robert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARSHAL L. NORRIS

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-5543

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	Divorced

6 (b) Name of husband or wife Lillie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1899

8. AGE: Years	Months	Days	If less than one day
49	4	17	hr. min.

9. Birthplace Rosyln, Maryland (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Coal Truck

FATHER
12. Name Lloyd Norris
13. Birthplace Maryland

MOTHER
14. Maiden Name Maria ?
15. Birthplace Maryland

16 (a) Informant Ida Derricks, sister
(b) Address 1034 N. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-48 (month) (day) (year)
(c) Cemetery or crematory St. Thomas
Location Randallstown, Md.

18 (a) Funeral director Samuel W. Sullivan, Jr.
(b) Address 1011 N. Arlington Ave.

DEC 2 - 1948 (Date rec'd by registrar) (By) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1948, at 1.45p M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH. Cerebral Hemorrhage Spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, in industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Rey M.D. (Medical Examiner)
Date signed December 2, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G690686 ✓ G690686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1726 N.Wolfe Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 52 ##Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 N.Wolfe Street (If rural give location)
(e) Citizen of foreign country? No Yes or No
If yes, name country

3 (a) FULL NAME Minnie I. Atzrodt (Minnie Berry Atzrodt)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Claude Atzrodt
6 (d) If alive, give age D years

7. Birth date of deceased mo., day, yr Jan.12,1880

8. AGE: Years	Months	Days	If less than one day
68	10	20	########## min.

9. Birthplace Baltimore County, Meryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Martin L.Widerman
13 Birthplace Baltimore, County

MOTHER
14. Maiden Name Susan Mullinaux
15 Birthplace Baltimore, County

16 (a) Informant Mrs.Lydia W.Sheffer (Sister)
(b) Address 3134 Woodhome Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec.4,1948 (month) (day) (year)
(c) Cemetery or crematory Mt.Olive Cemetery
Location Randallstown, Balto:Co.Md.

18 (a) Funeral director George J.Ruth, Inc.
(b) Address 1735 Harford Avenue

DEC 2 - 1948 (Date received by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Dec 1948, at 8 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1948 to Dec 1 1948, and that I last saw h alive on 29 Nov 1948.

Immediate cause of death	Duration
Coronary occlusion	
Due to Coronary arteriosclerosis	5 yrs.
Due to Generalized arteriosclerosis	"
Other Conditions Diabetes with amputation both legs (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature Henry J. Conolly
Address 13 E. Eager St. Date signed Dec 1 1948

VS 150

94a

66067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 66067

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1306 E. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 1306 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE W. HOWARD

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-5720

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Martha Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 25, 1885

8. AGE: Years 63 | Months 11. 10 | Days 25 5 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired Insurance & Trust Co

11. Industry or business

FATHER
12. Name John. Howard
13 Birthplace Baltimore

MOTHER
14. Maiden Name Margaretta Ward
15 Birthplace Baltimore Md

16 (a) Informant Martha Howard
(b) Address 1306 E. Pratt St

17 (a) [illegible] Burial. (Burial, cremation, or removal) (b) Date thereof [illegible] (month) (day)

(c) Cemetery or crematory Baltimore Cem
Location Northern Ave & Rose St

18 (a) Funeral director Kendall Roper
(b) Address 312 S. Highland Ave

19 (a) DEC 2 - 1948 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1948 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1947 to Nov 30 1948 and that I last saw alive on Nov 29 1948

Immediate cause of death Bronchogenic Carcinoma — Duration 1 yr

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work?)
(e) Means of injury

23. Signature Nelson L. Soman, M.D.
Address 129 S. Broadway Date signed 12/1/48

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 15?

66:088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

Registered No. 66:088

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or ~~xxxxxx~~ St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 N. Bond (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a). FULL NAME Mattie Lee Cabell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Colored	

6 (b) Name of husband or wife George Cabell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1887

8. AGE: Years	Months	Days	If less than one day: hr.	min.
61	5 6	28		

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Hope
13. Birthplace Georgia

MOTHER
14. Maiden Name Mattie White
15. Birthplace Georgia

16 (a) Informant Rev. Hay Tunsell
(b) Address 423 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2 1948 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Brooklyn Md.

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brantly Ave

DEC 2 - 1948 (Date rec'd by registrar) Huntington Williams Mar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1948, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20, 1948, to Nov. 28, 1948, and that I last saw her alive on Nov. 28, 1948.

Immediate cause of death	Duration
Cardio-respiratory Failure	
Due to - Hypostatic pneumonia	
Due to Uremia	
Other Conditions Tuberculosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: - Cholecystitis - Tuberculosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (While at work)
(Specify)
(e) Means of injury

23. Signature Eugene J. Riley, M.D.
Address 2 Longwood Apts. Date signed 11/29/48

X.

VS 150

Please print plainly with pen or pencil. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

669089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

669089 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 09 Murdock Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. John Joseph Volz (Augusta) AUGUSTA ELIZABETH VOLZ
3 (b) If veteran, name war
3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1948, at 1:20 AM

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Married

6 (b) Name of husband or wife John Volz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1886

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	8	8		

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Mr. George Buck
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Amelia Bowers
15. Birthplace Pennsylvania

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/48 (month) (day) (year)
(c) Cemetery or ~~dewelry~~ Baltimore
Location North Ave. & Rose St., Balto. Md.

18 (a) Funeral director Schimunek Funeral Home, Inc.
(b) Address 2601-3-5 E. Madison St., Huntington Williams, Mgr.

19 DEC 2 - 1948 (Date rec'd by registrar) Registrar

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 19 48 to Nov 30 19 48, and that I last saw her alive on Nov. 30 19 48.

Immediate cause of death Chronic congestive heart failure — Duration 3 weeks
Due to Arterio sclerotic heart disease — years
Due to
Other Conditions diabetes mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Francis A Wait M. D.
Address Union Memorial Hosp Date signed 11-30-48

VS 150

93 D

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Please write the correct age is especially important.

66A030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 66A030

66A030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Gough Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (if outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Gough Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Kavanaugh

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/25/ 1877

8. AGE: Years	Months	Days	If less than one day
71		5	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Garrett Kavanaugh
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Nevin
15. Birthplace Ireland

16 (a) Informant Mrs. Bridget Mary Lewis
(b) Address 2117 Gough Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/ 48 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Edmondson Ave. Balto. Md.

18 (a) Funeral director Lilly & Zeiler, Inc
(b) Address 403 S. Wolfe St.

19 (a) DEC 2 - 1948 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 19 48, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 19 48, to Nov. 30 19 48, and that I last saw her alive on Nov. 29 19 48.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm D Ickert M. D.
Address 701 N. Kenwood Ave. Date signed 12/1/48

669091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13R

669091 Registered No.

LCH-124605

Physicians: please write the causes of death clearly and legibly. Any information not available, correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 937 N. Calvert Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joe P. Kelly

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Seperated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6/17/1898

8. AGE: Years	Months	Days	If less than one day
50	5	6	hr. min.

9. Birthplace Fla. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joe Kelly (d)
13. Birthplace ?

MOTHER
14. Maiden Name Mary Lason (d)
15. Birthplace ?

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 12-9-48 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery ~~or crematory~~ Cathedral
Location Baltimore, Md.

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) DEC 2 - 1948 (Date rec'd by registrar) (b) Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23/48 19 at 3:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15/48 19 to 11/23/48 19 and that I last saw him alive on 11/23/48 19

Immediate cause of death	Duration
(a) Far Advanced Pulmonary Tuberculosis	1 yr.
Due to	
Due to	
Other Conditions Portal cirrhosis ?	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Frank M. Slaughter M.D.
Address Balto. City Hosp. Date signed 11-30-48

VS 150

G69092

ES-124748

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G69092

117a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: BALTO. CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 831 S. Linwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Seyfferth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 13, 1884

8. AGE: Years	Months	Days	If less than one day
64	4	17	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Mechanic
11. Industry or business Continental Can Co.

FATHER
12. Name Frank Seyfferth
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant RECORDS-BALTO. CITY HOSPITALS
(b) Address 4940 EASTERN AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4/48 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern Ave Rd.

18 (a) Funeral director John J. Duda
(b) Address 2229 Baldwin St.

19 DEC 2 - 1948 Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30 1948, at 4:20 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11-21 1948 to 11-30 1948 and that I last saw h in alive on 11-30 1948.

Immediate cause of death Bronchopneumonia
Pulmonary Edema — Duration 3 days

Due to Hypertensive Cardio-vascular disease with failure

Due to

Other Conditions Peptic ulcer
Esophageal Varices, 2ndary Anemia
(Include pregnancy within 3 months of death)

Dat of operation 11/26/48

Major findings of operation: Peptic Ulcer (Gastric)

of autopsy: same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank S. Kandt M.D.
Address Balt. City Hosp Date signed Dec 1, 194

Physicians: please write the causes of death clearly and legibly. Especially important. correct age is especially important.

VS 150

66803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 156a 66803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Carey Streets
(c) Hospital or institution: Good Samaritan Nursing Home 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 N. Payson Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ACIE CARTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rita Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1898

8. AGE: Years 50 | Months 4 | Days 5 | If less than one day: hr. min

9. Birthplace Summerton, S.C. (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER
12. Name
13. Birthplace South Carolina

MOTHER
14. Maiden Name Parsons
15. Birthplace South Carolina

16 (a) Informant Odessa O. Hughes
(b) Address 1410 E. Chase Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/48 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus, Md.

18 (a) Funeral director CHARLES R. LAW
(b) Address 802 Madison Avenue

19 (a) DEC 2 - 1948 (Date filed by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Novemb r 30 1948 11:15 AM

21. I certify that I took charge of the remains described above, held an Ins. & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Necrosis of Rt. Hip
Malnutrition

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary or some contributory cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on a public highway, or in industrial place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner

Date signed 12-1-48

VS 151

PLEASE WRITE PLAINLY, with unfading ink. Be sure to give correct age in years. Physicians: please write the causes of death clearly and legibly.

69094

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 166

Registered No. 69094

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RFD and box number)
(d) Street, No. 524 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES WEEMS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/16/28

8. AGE: Years 20 | Months 9 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James T. Weems
13. Birthplace Md.

MOTHER
14. Maiden Name Julia F. Sembly
15. Birthplace Md.

16 (a) Informant Julia F. S. Weems
(b) Address 524 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-48 (month) (day) (year)
(c) Cemetery or crematory Bat. National
Location Baltimore, Md.

18 (a) Funeral director Charles R. Lee
(b) Address 502 Madison Ave.

19 (a) DEC 2 - 1948 (Date rec'd by registrar) (b) Huntington Ave. Baltimore Md. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2, 1948; 7:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wounds of heart, lungs, liver and stomach.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was [ ] primary [ ] not contributing [ ] cause of death, fill in the following:
(a) Date of injury Dec. 2, '48 Approx. 6:50 P.M.
(b) Where did injury occur? Biddle & Druid Hill
(c) Did injury occur at home, on farm, industrial place, or public place) Public While at work? No
(d) Means of injury Firearms

23. Signature Hugo G. Wessell M.D.
Medical Examiner

Date signed 12/2/48

PLEASE WRITE PLAINLY with pen and ink. Every item of information called for on this certificate should be answered. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 66,035

66,035

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts.

(c) Hospital or institution: Mercy Hospital 6-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 day

(e) Length of stay in Baltimore (yrs., mos., or days) 66 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 128 N. Belnord Ave. (If rural give location)

(e) Citizen of foreign country? No. Yes or No

If yes, name country

3 (a) FULL NAME Cecelia Sadowski - CECILIA SADOWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/18/1871

8. AGE: Years	Months	Days	If less than one day: hr.	min
77	6	14		

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Joseph Sadowski

13. Birthplace Poland

MOTHER 14. Maiden Name Eva Chodorski

15. Birthplace Poland

16 (a) Informant Agnes Sadowski

(b) Address 128 N. Belnord Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/48 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Sons

(b) Address 1808 Eastern Avenue

19 (Date rec'd by registrar) DEC 2 - 1948 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1/48 19 , at 10 Yrs. AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21 1948 to 12/1 1948

and that I last saw h[illegible] alive on 12/1 1948

Immediate cause of death	Duration
Cardiac failure	
Due to Asterio sclerosis	
Cardio - vascular lesion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(e) Means of injury

23. Signature Henry V. Chase

Address Mercy Hospital Date signed 12/1/48

VS 150

669096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 567

669096 Registered No.

Please write plainly, with ink. Use no abbreviations. Physicians: please write the causes of death clearly and legibly. Give exact residence of deceased. Name of institution is not sufficient. If residence is in city, give number of house and street. Do not report occupation of housewife. Give correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 Lansing Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Lansing Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH ANDREW DERNETZ

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 217-03- 8122

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Catherine
6 (c) If alive, give age 53 years

7. Birth date of deceased mo., day, yr. Dec. 1, 1894

8. AGE: Years	Months	Days	If less than one day
54	0	0	hr / min

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Glenn L. Martin Co.

FATHER
12. Name Vincent Dernetz
13. Birthplace

MOTHER
14. Maiden Name Josepha peloblaver
15. Birthplace

16 (a) Informant Mrs. Mary C. Dernetz
(b) Address 1706 Lansing Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/48 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 2 - 1948 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 1, 1948 at 4.55 M

21. I certify that death occurred on the date above stated, that I attended deceased from May 29 1948 to Dec 1 1948 and that I last saw him alive on Nov 29 1948

Immediate cause of death: Chronic Cystitis
Multiple infected bed sores
Paraplegia

Due to

Due to Hemorrhage of pleural cord

Other Conditions

Duration

Date of operation Aug 1948

Major findings of operation:

of autopsy:

PHYSICIAN

22. If death was due to external causes, fill in the following:
(d) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Date signed

669097

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

669097
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 Aiken St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 Aiken St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME THOMAS JACKSON HORNADAY

3 (b) If veteran, name war W. W. I

3 (c) Social Security Account No. 216-10-0497

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose Marie Ruzicka

6 (c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.) Oct. 10. 1891

8. AGE: Years 57 | Months 1 | Days 20 | If less than one day: hr. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: Thomas Hornaday
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Not Known
15. Birthplace: North Carolina

16 (a) Informant: Mrs. Rose M. Hornaday (Wife)
(b) Address: 2215 Aiken St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 3. 1948 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location: Baltimore Md.

18 (a) Funeral director: HENRY SANDER & SONS. INC.
(b) Address: Baltimore Md.

19 (a) DEC 2 - 1948 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30. 1948 at 1.00 A.M.

21. I certify that death occurred on the date above stated that I attended deceased from Mar 25 47 to Nov 30 48 and that I last saw him alive on Nov 29 48

Immediate cause of death: Coronary Thrombosis — Duration 11/29/48

Due to: Chronic Myocarditis — 3/.../47

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: William J. Ryan M.D.
Address: 801 N. Eastwood Ave. Date signed: 12/1/48

PLEASE WRITE PLAINLY, with unfading ink. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

66098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. 66098

PLEASE WRITE PLAINLY with pen or indelible pencil. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Chilton St., (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Harmon Wilkinson

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-03-1286

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Fannie Christine
6 (c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): June 30, 1888

8. AGE: Years	Months	Days	If less than one day: hr.	min
60	5	1		

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Wire Chief

11. Industry or business: Western Union Telegraph Co.

FATHER
12. Name: Robert W. Wilkinson
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Ethel V. Vorsteg
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Fannie C. Wilkinson
(b) Address: 1630 Chilton Street

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof: 12/4/48 (month) (day) (year)
(c) Cemetery or crematory: Moreland Memorial
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) DEC 2 - 1948 (Date rec'd by registrar) Frances Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1, 1948, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8/ 1948 to 12/1/ 1948, and that I last saw him alive on 12/1/ 1948.

Immediate cause of death: Bronchopneumonia + Renal failure — Duration

Due to: Post Operative complication of Subtotal gastrectomy

Due to:

Other Conditions (include pregnancy within 3 months of death)

Date of operation: 11-24-48

Major findings of operation: Gastric ulcer

of autopsy:

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature: William F. Roetzer, M.D.
Address: 1 Scott Medical Bldg. Date signed: Dec 1, 1948

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

669093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 669093

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Redwood Hotel, Redwood & Light St. (If rural, give location)
(e) Citizen of foreign country? Yes or No?
If yes, name country

3 (a) FULL NAME ALBERT LEE CRAIG

3 (b) If veteran, name war: W.W.1

3 (c) Social Security Account No. 579-12-07

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1898

8. AGE: Years: 50 yrs. Months: 7 Days: 14? If less than one day: hr. min

9. Birthplace: Alabama (Town, county, and state)

10. Usual Occupation: Seaman

11. Industry or business

FATHER
12. Name: E. M. Craig
13 Birthplace: Alabama

MOTHER
14. Maiden Name: Mary Smith
15. Birthplace: Alabama

16 (a) Informant: Mr. Fred. Craig
(b) Address: Dade City, Florida

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/48 (month) (day) (year)
(c) Cemetery or crematory: Dade City Cemetery
Location: Dade City, Florida

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

19 (a) (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1948 at 11:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, or public place? While at work?
(d) Means of injury

23. Signature Earl L. Royster M.D.
Medical Examiner.

Date signed 12/2/48

VS 151

Please write plainly, with pen or pencil, and do not use ditto marks. Be sure to answer all questions. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

86300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

Registered No. (illegible)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmond & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 936 Argyle Ave.,
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** WALTER JACKSON.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased: mo., day, yr April 1, 1900.

8. AGE: Years	Months	Days	If less than one day: hr	min
48	7	28		

9. Birthplace Frederick, Md.,
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John O. Jackson.
13. Birthplace Calvert Co., Md.,

MOTHER
14. Maiden Name Ellen Stanley,
15. Birthplace Md.

16 (a) Informant Elmer Jackson
(b) Address 936 Argyle Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4, 1948 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 328 N. Schroeder St.

19 (a) DEC 2 - 1948 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-29 1948, at 1 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1948, to 11-27 1948, and that I last saw h/m alive on 11-27 1948.

Immediate cause of death: Cardiac failure — Duration

Due to arteriosclerotic C-V.

Due to Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address University Hospital Date signed 11-29-48

VS 150

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 9-9 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 6 4794 AND ENDING WITH 69100 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Bynes

END OF REEL